

# **STATE TITLE V BLOCK GRANT NARRATIVE**

**STATE: AL**

**APPLICATION YEAR: 2006**

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

Assurances and certifications are included in Appendix A. Appendices are not submitted electronically but are on file in the Bureau of Family Health Services, Alabama Department of Public Health. Any appendix, including Appendix A, can be obtained upon request by calling, e-mailing, or faxing the Bureau of Family Health Services' Epidemiology and Data Management Branch (phone: 334.206.5943; e-mail: [acowden@adph.state.al.us](mailto:acowden@adph.state.al.us); fax: 334.206.2914).

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

The Bureau of Family Health Services (Bureau), Alabama Department of Public Health, seeks public input via the needs assessment process and distribution of needs assessment reports. During the fiscal year (FY) 2004-05 maternal and child health (MCH) needs assessment, the Bureau sought input via mailed surveys, 1 of primary care providers and 1 of non-medical organizations serving Title V populations; 20 community discussion groups, 10 of which were analyzed; and a diverse MCH Needs Assessment Advisory Group. Methods for and findings from the preceding 3 approaches are detailed in 5-year needs assessment report. Plans for soliciting future input include preparation and distribution of a public-friendly report of the FY 2004-05 MCH needs assessment, which will solicit readers' comments. As well, the Bureau will continue seeking input from the State Perinatal Advisory Council.

Children's Rehabilitation Service (CRS), Alabama Department of Rehabilitation Services, administers services to children and youth with special health care needs (CYSHCN) and seeks input from this population. In June, 2005 CRS presented the FY 2006 draft State plan, needs assessment findings, and documentation of characteristics listed on Form 13 at a meeting of the State Parent Advisory Committee. For more input CRS has relied heavily on the FY 2004-05 MCH needs assessment process, which includes open family and youth forums, county-level provider surveys, youth surveys, and an interagency advisory group.

## **II. NEEDS ASSESSMENT**

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

Acronyms or shortened terms are listed in Appendix B, obtainable by calling 334.206.5943 or e-mailing [acowden@adph.state.al.us](mailto:acowden@adph.state.al.us). Further, Appendix B is included as an attachment to III.A. Other appendices are not included in this web-based submission but are obtainable through the above phone number and e-mail address.

In the State of Alabama (State), the Title V Program is administered by the Alabama Department of Public Health (ADPH, or Department) through the Bureau of Family Health Services (Bureau, Family Health Services, or FHS). FHS does not directly administer aspects focusing on CYSHCN but contracts with CRS, within the Alabama Department of Rehabilitation Services (ADRS), which administers services to this population. In addition to the Title V Program, FHS administers the Title X Family Planning Grant; and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); the State Perinatal Program; the Alabama Child Death Review System; and the State Dental Program. The Title V Program, as well as these other programs, serves all of the State's 67 counties.

#### **THE HEALTH CARE ENVIRONMENT**

MCH Services Block Grant annual reports for FYs 1997 and onward have described changes that have been occurring in Alabama's health care environment over the last several years. These changes caused a shift in the provision of direct medical services from county health departments (CHDs) to private providers. As a corollary, the changes prompted a paradigm shift concerning the roles of CHDs--toward a greater emphasis on the core public health functions of assessment, policy development, and assurance. This shift has been especially evident with respect to the provision of services to pregnant women and to children and youth. Because the shift continues to influence the Department's role in providing services, salient history pertaining to the health care environment is summarized here.

#### **Medicaid Managed Care Programs**

A discussion of previous and current Medicaid managed care programs, as well as case management or care coordination services provided concurrently with these programs, follows.

#### **Medicaid Maternity Care Program**

Under the Alabama Medicaid Agency's (Medicaid's) Maternity Waiver Program that had been implemented in 1988, ADPH had been the primary provider of prenatal care for 23 of the State's 67 counties and subcontractor for care in many other counties. Under this plan, many women eligible for Medicaid-funded services under the Sixth Omnibus Budget Reconciliation Act (SOBRA) received their prenatal clinical health care and care coordination services mainly through CHDs. In an interview with the pregnant patient, the care coordinator explained the Medicaid Maternity Waiver Program, helped her apply for SOBRA Medicaid, completed a psychosocial assessment and written case plan, provided her with a list of medical providers and arranged for an appointment with the chosen provider, and referred her to WIC and any needed community resources. The care coordinator then monitored the patient through the time of the postpartum visit, which was to occur 4-6 weeks after delivery, to assure that the patient obtained postpartum care and had access to family planning options. Home visits were made for high risk patients: that is (i.e.), if the mother was less than 16 years of age or tested positive for human immunodeficiency virus (HIV); if there were indications of substance abuse or domestic violence; or if the baby was premature, low birthweight, or had special needs.

The Department's role in directly providing prenatal care has markedly declined with Medicaid's current State Plan for Maternity Care, which was begun in June 1999 and fully implemented by October 1999. This current State Plan for maternity care divides the State into 13 Medicaid maternity districts. Under this plan, ADPH no longer provides maternity services via a direct contract with Medicaid. Instead, with implementation of Medicaid's current State Plan for Maternity Care, ADPH began providing prenatal care and/or case management in certain counties, via subcontracts with

groups who assumed responsibility for provision of prenatal care under a direct contract with Medicaid. However, even the number of counties in which ADPH subcontracts to provide prenatal care or case management for pregnant women has substantially declined in recent years. Specifically, the number of counties in which ADPH provides prenatal care as a subcontractor has declined from 14 circa FY 2000, to 10 by FY 2003, to 9 as of July 2004. The latter decline occurred because, in May 2004, prenatal care that had previously been provided by the Jefferson County Department of Health (JCDH) was transferred to the University of Alabama at Birmingham (UAB). Further, the number of counties in which ADPH provides case management as a subcontractor declined from 54 circa FY 2000 to 28 in FY 2002. As a corollary, as discussed later in this section, the number of patients receiving prenatal care in ADPH clinics has declined markedly.

By March 2005 it was determined that the private sector had both the desire and capacity to provide all the prenatal care required under the SOBRA Medicaid program. For this reason and because of financial and liability-related issues, ADPH decided to completely withdraw from providing prenatal care. Most CHDs made a parallel decision to no longer provide care coordination for pregnant patients, though a few CHDs may continue to work with private providers in the provision of care coordination services only.

#### Patient 1st and Case Management/Care Coordination

The course of the Patient 1st Program, a primary care case management program (PCCM) implemented by Medicaid, affects provision of case management or care coordination by ADPH staff to nonpregnant individuals. For this reason, an integrated discussion of the history of Patient 1st and of care coordination/case management of nonpregnant individuals follows. Case management and care coordination help patients to access medical, social, and educational services and other community resources. In this report the terms "case management" and "care coordination" pertain to the same service--though some programs use one term and some the other.

Medicaid fully implemented Patient 1st by November 1998, when all Alabama counties except Mobile used the Patient 1st model. (Mobile County later began participating in the Patient 1st Program and continues to do so.) The Patient 1st model assigned all Medicaid recipients, including CYSHCN, in a county to a medical home that managed their health care needs, including referrals for specialty care and pre-authorization of specified Medicaid services. Many believed that Patient 1st increased access to primary care for Medicaid recipients, including CYSHCN. Under Patient 1st, though a few CHDs provided some child health services through memorandums of understanding with private providers, the number of children seen in ADPH clinics for care declined markedly, as discussed later in this section. PCCM and a prior increase in willingness of private providers to see Medicaid-enrolled patients were thought to be major factors in this decline.

As the need and/or opportunities for provision of direct health care services to children and youth in the CHD setting diminished, FHS and some CHDs shifted their focus from direct services provided in the CHD to enabling services and community-based services. This shift gave rise to increased emphasis on provision of case management/care coordination services by licensed public health social workers and nurses. Case managers/care coordinators worked in several clinical programs, including family planning, child health, and Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS). While Patient 1st as originally implemented was in force (November 1998 through February 2004), ADPH provided case management to certain medically at risk children through the Medically at Risk (MAR) Case Management Program. As of early calendar year (CY) 2001, most MAR Referrals were for immunizations, dental care, appointments missed for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), social systems issues, specialty referral coordination, and problems with a medical regimen. As of early FY 2004, about 45 full time nursing or social worker equivalents were working as MAR care coordinators under the Patient 1st Program.

In early FY 2004 the State's governor (Governor) appointed a new Medicaid Commissioner, who has a strong interest in and ties with MCH. Medicaid then discontinued Patient 1st, effective March 1, 2004, because of financial constraints and waiver expiration. When Patient 1st ended, Medicaid-

enrolled patients were no longer assigned to a primary care provider and could receive services from any physician who provided services under the Medicaid Program, but Medicaid no longer reimbursed for provision of care coordination services to adults. Further, because the MAR Case Management Program was closely tied to the originally implemented Patient 1st, MAR Case Management also ended effective March 1, 2004. However, through an agreement with Medicaid, ADPH continued to provide care coordination to children and adolescents (through 20 years of age) under EPSDT guidelines. Under EPSDT care coordination, children and youth through 20 years of age who had full Medicaid coverage could receive care coordination at CHDs. Though Patient 1st was no longer in force, ADPH's policy was to perform EPSDT screenings in CHDs only for children and youth who could not access such screenings through private providers. Medicaid, ADPH, and CRS continued to support the concept of a medical home for patients.

Many rural medical providers had depended heavily on the Patient 1st case management fees paid by Medicaid to fund their practices. For this and other reasons, primary medical providers in the State petitioned Medicaid to restart the managed care program. A task force, which included representatives from CRS and ADPH, was established to create a new waiver for a revised managed care program for Medicaid enrollees. The Patient 1st Program was redesigned and reinstated in increments, beginning December 1, 2004. Counties were slowly added back into the program, with all counties being a part of Patient 1st by February 1, 2005. The reinstated Patient 1st Program has a similar structure to that of the previous program and provides financial incentives for physicians to provide a true medical home and perform EPSDT screenings. Medicaid pays the provider graduated case management fees, determined by the components of care (e.g., providers' availability after office hours) that the provider agrees to incorporate. The reinstated program includes increased quality assurance efforts, performance-based goals, and a greater focus on affecting behavior through providers playing a more active role in patient education.

One Patient 1st design change that had a major impact on ADPH is that Medicaid no longer requires a referral from the patient's primary medical provider in order to provide care coordination services to children and adults. The removal of this barrier has allowed ADPH care coordinators to receive referrals from a variety of sources, including schools, hospitals, and self referrals by patients and families. Further, ADPH central office staff are now able to refer children with elevated lead levels, infants who fail their newborn hearing screenings, and infants identified with certain conditions at birth through the newborn hematologic screening program for care coordination by trained CHD staff. Moreover, CHD care coordinators can now provide information and counseling on birth control methods and sexually transmitted diseases, including HIV infection, to Medicaid-enrolled teens who present for family planning services. Reimbursement by Medicaid for these services has been particularly valuable in light of the recent loss of funding from the Department of Human Resources (DHR) for teen care coordination (discussed later in this section).

#### Collaboration between CRS and Medicaid

The Medicaid commissioner, who has strong ties to MCH, has emphasized children's issues as an agency priority. To this end, CRS has specific Medicaid staff members assigned to work with its programs. Meetings between Medicaid and CRS are conducted on a quarterly basis, which has led to greater coordination and communication between the agencies. This enhanced partnership has facilitated collaboration such that CRS has established procedures to bill for therapy services provided by vendors, thus increasing access of Medicaid-covered CYSHCN to small therapy-provider groups. CRS credentials its staff and vendor physical, occupational, and speech therapists, and licensed physical therapist assistants and certified occupational therapist assistants according to the Medicaid Administrative Code to provide services to clients in CRS-sponsored early-intervention programs and/or the CRS program. A list of approved multidisciplinary clinics within the Children's Specialty Clinic Program, with required minimum staff, has been negotiated with Medicaid to ensure consistent quality and statewide standards of care. CRS has an ongoing collaboration with Medicaid to meet HIPAA standards for privacy and billing and to provide access for Medicaid-enrolled children to community-based medical specialty clinics. CRS has become a direct provider with Medicaid for audiological services, hearing aids, and related supplies, thereby providing better coordination of these services for Medicaid-eligible CRS clients. CRS also serves as the reviewer of all requests for

Medicaid funding for augmentative communication devices and power wheelchairs.

#### Medicaid Family Planning Waiver and Related Issues

The 1115(a) Family Planning Waiver Proposal, submitted by ADPH and Medicaid to the Health Care Financing Administration (HCFA) in FY 1999, was implemented in October 2000. The Waiver expanded Medicaid eligibility for family planning services for women aged 19-44 years to 133% of the federal poverty level (FPL). (The previous eligibility cut-off had been about 16% of FPL.) Family planning services for adolescents less than 19 years old were already covered by Alabama's State Child Health Insurance Program (SCHIP, discussed later in this section), which then provided Medicaid coverage for those at or below 100% of the FPL and private insurance coverage for those between 100% and 200% of the FPL. Care coordination and outreach were major components of the Family Planning Waiver Proposal.

In June 2001 DHR funded a Teen Family Planning Care Coordination program at ADPH, with the goal of reducing the frequency of pregnancies and abortions among teens in Alabama. Under this program, all teens 18 years old and younger who presented at any CHD for family planning services were eligible for care coordination. Because of the cuts in federal Temporary Assistance to Needy Families (TANF) funds to the State, this program began being phased out around March 2004 and was terminated by September 30, 2004. However, half of the teens being served in the program as its termination approached were enrolled in Medicaid, so were eligible to receive the same services via the previously referenced EPSDT Care Coordination Program.

#### The State Children's Health Insurance Program

With the creation of Alabama's Children's Health Insurance Commission in August 1997, the State Legislature appropriated funds and designated ADPH as the lead agency for this program. SCHIP was planned and implemented in Alabama using a broad-based workgroup, formed in September 1997, to research and recommend how services for the uninsured could best be developed. The workgroup included other State agencies (Medicaid, DHR, ADRS, Alabama Department of Mental Health and Mental Retardation [MHMR], State Department of Education [SDE], State Employees' Insurance Board), advocacy groups (Alabama Arise, Family Voices, and VOICES for Alabama's Children), hospitals, community health centers, and various professional associations. Phase 1, a limited Medicaid expansion, was begun in February 1998. Phase 2 (the ALL Kids Program), a private insurance package for children between 100% and 200% of the FPL, began on October 1, 1998.

Alabama SCHIP is administered through the Department's Office of Children's Health Insurance. Title V (both Family Health Services and CRS) staff have been heavily involved in the program's efforts, serving on workgroups to develop enhancement packages and recommendations on how the program should work. Alabama was the 1st state in the nation to have a federally approved SCHIP State Plan as well as the 1st to have a major plan expansion.

Several years ago Medicaid and SCHIP began utilizing a joint application form for the Medicaid and ALL Kid components of SCHIP. The joint application made applying for these programs much simpler and referrals between these programs more automated and streamlined, and substantial numbers of children were added to SOBRA Medicaid rolls over the years. ADPH believes that many of these children were added because of intensive SCHIP outreach and collaboration between Medicaid and SCHIP regarding the application process. Due to incremental, federally mandated Medicaid coverage of persons from 6-19 years of age with household incomes below 100% of FPL, ALL Kids became the sole component of SCHIP in FY 2004. (For this reason, in this document "SCHIP" and "ALL Kids" are used interchangeably to refer to Alabama's State Health Insurance Program.) Medicaid and SCHIP staff continue collaboration regarding the application process, however. Additional activities designed to inform the public about SCHIP and to promote enrollment of eligible children in ALL Kids, Medicaid, or the Alabama Caring Foundation insurance plan are described under NPM #13. These activities include coordination and simplification of the application process.

Further, as described under NPM #18, FHS staff and Alabama SCHIP staff are collaborating regarding the feasibility of expanding SCHIP coverage to include the unborn child. That is, plans are

being considered to cover pregnant women whose household income does not exceed 133% of the FPL and who are not already eligible for coverage by another entity.

#### Department of Children's Affairs

The Department of Children's Affairs (DCA) was created in 1999 through legislation endorsed by the Governor. Per their web site ([www.dca.state.al.us](http://www.dca.state.al.us)), the DCA's mission is "to provide state leadership to identify, analyze, streamline, and coordinate services for the 1.2 million children ages 0-19 throughout Alabama." This mission is accomplished through 4 divisions within the DCA: 1) Service Information and Evaluation; 2) Service Funding and Training; 3) Early Learning, in which The Head Start State Collaboration Office and the Office of School Readiness are administratively located; and Service Coordination and Support, in which the State Children's Policy Council (CPC) and CPC Field Directors are administratively located. Per the CPC's County Needs Assessment 2004-2005, "DCA is mandated to advise and educate the Governor, Legislature, and citizens of Alabama on all matters relating to children (reference #1). (References are listed in Appendix C, available as described in the first paragraph under Section III.A.) DCA was instrumental in convening the Children's Summit meeting in November 2000, which led to the creation of Alabama's 5-Year Strategic Plan for Children. Through the State CPC, DCA prepares and submits for approval and adoption legislation required to meet the unmet needs of children. DCA submits annual reports to the governor and the State Legislature on activities and expenditures of State and local agencies related to children. The Governor--who has been a strong supporter and advocate for children's issues, including education, health insurance coverage, and health care provision--continues his support for the DCA and CPCs.

Over their most recent reporting period (March 2004 to November 2005), the State CPC's activities, some of which had also been carried out in prior years, included the following: managing the growth and development of 67 local CPCs across the State; organizing and sponsoring the annual statewide CPC conference, which is attended by persons from each of the State's counties; managing and providing oversight for the budgeting of Children First Trust Fund (described later in this section) dollars; publishing the State CPC's Annual Needs Assessment from 67 counties; maintaining the work of Alabama's Head Start Program; cosponsoring (along with ADPH and others) the Oral Health Summit to identify barriers and strategies to promote oral health in Alabama; cosponsoring the Black Belt Health Summit; organizing a statewide Hispanic Coalition; and cosponsoring the first Statewide Fatherhood Conference.

The previously referenced State CPC's needs assessment report provides salient information on issues pertaining to the health of children and information. This information is utilized by Family Health Services' Child Health staff when assessing how the Department provides services for children and youth at the local level. Further, using funds from the federal Early Childhood Comprehensive Systems Planning Grant awarded to ADPH and administered through the Child Health Branch, ADPH contracted with DCA to receive information on infants and young children. Via this contract, the Director of DCA's Service Coordination and Support Division provided the Child Health Branch with information, from their needs assignment, on children from birth through 5 years of age. Additionally, staff with the Healthy Child Care Alabama Project, located in the Child Health Branch, collaborate with staff from DCA's Head Start State Collaboration Office. Moreover, FHS contacted DCA to identify persons who could represent DCA, the State CPC, and/or a local CPC at the January 2005 meeting of the MCH Needs Assessment Advisory Group (MCH Advisory Group). The Director of DCA's Service Coordination and Support Division attended the meeting.

ADRS, including CRS, the Alabama Early Intervention System (EIS), and Vocational Rehabilitation Service (VRS), is active at both the State and local levels with the CPCs, as a voice for children and youth with disabilities. A staff member from ADRS sits on local CPCs in all counties. CRS staff and local parent consultants attended the CPC's statewide conference in March 2005, which included workshops related to substance abuse prevention, family resource centers, rural health, planning and development, early childhood, and emerging topics. Training was provided on needs assessment and strategic planning at the county level, grant writing, resource directory development, and creation of children's advocacy in communities.



### Governor's Task Force on Children's Health Insurance

The previous Governor, through the State Health Officer, convened the Governor's Task Force on Children's Health Insurance (CHI Task Force) in July 2000 and designated a local pediatrician as the chair of this group. The DCA Commissioner served as the vice-chair and the DCA Deputy Commissioner as the secretary. The Task Force membership, appointed by the previous Governor, included State agency directors, child health advocates, and pediatric health care providers, including the chief executive officer of The Children's Hospital of Alabama (TCHA).

The CHI Task Force was charged with coordinating existing funds to determine how to provide health insurance to children not otherwise eligible for Medicaid, developing a comprehensive strategy to expand Medicaid eligibility, and developing a comprehensive strategy to reduce the percentage of Alabama's children without health insurance. The final report of the CHI Task Force contained 29 recommendations and was presented to the Governor in January 2001. Recommendations on outreach included 1) simplifying and coordinating the enrollment process for the 4 children's health insurance programs (Medicaid for Low-Income Families, SOBRA Medicaid, ALL Kids, and the Alabama Caring Foundation); and 2) developing public awareness strategies about eligibility for the 4 programs, with the strategies targeted to hospital staff, primary care physicians, child care providers, and public school staff. Recommendations about enrollment and eligibility included assuring an efficient, adequately staffed enrollment system for both ALL Kids and Medicaid, and streamlining of the annual renewal processes. Further, establishment of an adjunct "eligibility" for Medicaid based on income eligibility for other means-based programs, such as Food Stamps and subsidized child care, was suggested. Recommendations concerning providers, reimbursement, and financing included: 1) increasing Medicaid reimbursement rates to match Medicare rates for physician office visits and to match Blue Cross and Blue Shield of Alabama rates for dental procedures, 2) creating a fully automated, web-enabled enrollment system for ALL Kids and Medicaid, 3) describing the demographics for uninsured children at the county level, and 4) addressing long-term financing strategies for Medicaid. The CHI Task Force further recommended that an ADPH and Medicaid joint committee be formed to monitor progress on implementing recommendations.

Several developments occurred while the CHI Task Force was active. Medicaid convened a dental task force to look at issues affecting access to dental services for children who are Medicaid recipients, and collaborated with the Alabama Dental Association to survey dentists on what might encourage them to become Medicaid providers. With the Governor's approval, Medicaid increased its rates for dental procedures effective October 1, 2000. CRS also increased rates to at least match the new Medicaid rates. Further, Medicaid developed a plan for a functional assessment of orthodontic needs in order to expand its coverage of orthodontic treatment beyond children with craniofacial conditions to include other children with severe disabilities.

### Service to Certain Medicare Enrollees

Through expansions under the Medicare Program, various health plan options are available for clients with certain disabilities. This allows Medicare recipients to choose a benefit package that best meets their individual needs, which may challenge CRS clients in the selection of the most appropriate plan. CRS serves about 30 clients with Medicare benefits, most of whom are adults with bleeding disorders. Enrolling in the most beneficial option initially is preferable due to dis-enrollment penalties. CRS provides assistance to clients with Medicare coverage to select plans that address their needs.

### SELECTED CHANGES IN ALABAMA'S POPULATION

#### Increase in Hispanic/Latino Births

Comparing 2003 to 1999, the number of live births to Hispanic/Latino females residing in Alabama increased by 86.4%, or by 1,378 infants. This increase occurred for each maternal age group, as well as for all ages combined. The increase began over a decade ago. Specifically, the number of live births to Hispanic/Latino Alabama residents increased from 344 in 1990, to 1,595 in 1999: a 4.6-fold increase (or an increase of 364%). This number further increased to 2,972 in 2003, or 86.3% above the number in 1999. In 2003, 5.0% of live births were to Hispanic/Latino females, compared to 0.54% in 1990 and 2.5 percent in 1999. This increase in live births to Hispanic/Latino females is also discussed in Part 3 of the State's FY 2004-05 MCH Needs Assessment Report (Reference #2,

sometimes termed "Needs Assessment Report" in this document).

Further, trends in the number of Hispanic/Latino persons residing in Alabama, according to age group and as reported in Health Status Indicator (HSI) #06B, are discussed in the Needs Assessment Report (reference #2). A salient element of this discussion is that numbers of Hispanic/Latino adolescents and young adults (10-24 years of age) are notably higher than the 1999 projections. (See reference #2 for details.) Moreover, the number of 10-14 year-old Hispanic/Latino Alabama residents was 9.8% higher in 2003 than in 2000. The higher projected number of 20-24 year-old Hispanic/Latino youth in 2003 relative to the 1990s reinforces the need to assure that the Hispanic/Latino population can access family planning services and obtain health insurance coverage for prenatal and perinatal care. Moreover, as 10-14 year-old Hispanic youth age, access to health care for young adult Hispanic/Latino individuals will increase in importance.

Accordingly, FHS's Division of Women's and Children's Health implemented the Uncompensated Maternity Care Project in CY 2000, to better understand the needs of and serve pregnant women without private insurance or Medicaid coverage. Counties with relatively high proportions of Hispanic/Latino live births were targeted. In FY 2001 MCH Block Grant funds supported uncompensated maternity care in 20 counties, with about 170 patients being served in this manner. In FY 2002, however, MCH Block Grant funds supported uncompensated maternity care in 21 counties, with over 250 patients receiving services. However, due to funding reductions discussed in Section III.B, the Uncompensated Maternity Care Project was discontinued in early FY 2004.

#### Poverty Levels

Poverty levels are also discussed in Part 3 of the Needs Assessment Report (reference #2). As stated there, the Current Population Survey reports that, in 2003, 22.3% of Alabama residents under the age of 18 years were below 100% of the FPL, compared to 17.6% of U.S. residents under 18 years of age (reference #3). Considering the margin of statistical error, the estimated percentage of Alabama children and youth under 19 years of age whose household income is at or below 200% of FPL has not notably changed, as reported in online U.S. Census Bureau health insurance reports. (See Needs Assessment Report for further discussion of poverty levels.)

#### NUMBERS OF ALABAMA TITLE V-SERVED INDIVIDUALS

There has been a marked decline, over a period of several years, in the numbers of children and pregnant women receiving Title V-funded services in CHDs. These declines can be quantified by comparing Form 7 for the current year to the same form for previous MCH Block Grant Services reports/applications (MCH reports/applications). This discussion extends from FY 1999 through FY 2003, a period including 5 years. FY 2004 numbers for Form 7 are not available at this writing, but will be shown on Form 7 by the July 2005 submission date for this report/application.)

The estimated number of persons receiving Title V services has typically been more stable for infants than for other Title V populations, since all infants who receive newborn screening are considered to be Title V served. Per Form 7 for the specified years, an estimated 55,438 infants received Title V services in FY 2003, compared to 54,873 infants in FY 2002 and 58,924 in FY 1999. Thus, by FY 2003, the estimated number of Title V-served infants had increased by 1.0% compared to FY 2002, but had declined by 5.9% relative to 1999. The decline relative to 1999 roughly parallels the decline in the number of Alabama residential live births, which declined by 4.4% in 2003 relative to 1999. (The method for estimating the number of Title V-served infants is described in a note to Form 7.)

Per Form 7, 7,295 pregnant women received Title V services in FY 2003, compared to 6,883 in FY 2002 and 21,395 in 1999. Thus, by FY 2003, the estimated number of Title V-served pregnant women had increased by 6.0% relative to FY 2002, but declined by 65.9% relative to 1999. When viewed over a longer period, the dramatic nature of this decline is particularly striking. That is, the number of pregnant women served by Title V in FY 2003 was only about one-fourth the number served in FY 1997 (7,295 versus 28,989, for a decline of 74.8%).

Per Form 7, 32,174 children and youth received Title V services in FY 2003, compared to 34,154 in

FY 2002 and 56,504 in 1999. Thus, by FY 2003, the estimated number of Title V-served children and youth had declined by 5.8% relative to FY 2002, and by 43.1% relative to 1999. When viewed over a longer period, the large magnitude of this decline is even more evident. In FY 2003, the number of Title V-served children and youth was less than half the number served in FY 1997 (32,174 versus 76,357, for a decline of 57.9%).

Per Form 7, 96,355 "Others" received Title V services in FY 2003, compared to 98,577 in FY 2002 and 87,358 in 1999. Thus, by FY 2003, the estimated number of other Title V-served individuals had declined by 2.3% relative to FY 2002, but increased by 10.3% relative to 1999.

## STRATEGIC AND FUNDING ISSUES

### ADPH's Strategic Direction Project and Workgroup

Recognizing that recent changes in the health care environment will fundamentally change the way ADPH works to improve the public's health in Alabama for the 21st century, the Department formed a Strategic Direction Project in late summer of FY 1998. Family Health Services' Director was heavily involved in this process, as a member of the Workgroup. The Workgroup had representation from the State, area, and local levels, as well as many public health disciplines. The Workgroup's report was distributed to key State and area staff in February 1999. Three of the 5 overarching themes emerging from the Workgroup's deliberations remain especially pertinent to FHS' strategies to promote the health of Title V populations. These 3 themes are:

- 1) Acknowledgment of the trend away from provision of direct patient services in public health clinics toward more of a community focus, where public health workers assume new leadership roles to create healthy Alabama communities.
- 2) The increasing importance of an assurance role (going beyond provision of direct services, which is itself part of assurance) for public health within the community-wide focus.
- 3) The importance of maintaining a close association between the Department's mission and its programs, services, and grant pursuits.

### Family Health Services' Mission and Vision

The mission of Family Health Services is to protect and promote the health and safety of women, infants, children, youth, and their families through assessment of community status, development of health policy, and assurance that quality health services are available. The vision of FHS is that Alabama's families and the communities in which they live will be HEALTHY and SAFE. Recognizing that we cannot achieve our mission or bring about our vision alone, FHS engages in many collaborative relationships, some of which are described in numerous places in this document. Using the conceptual model of the 3 core public health functions--assessment, policy development, and assurance--FHS continues seeking to foster a paradigm shift around family health at all levels (State, area, and county) of ADPH. Simply stated, this shift involves a move from direct health care services to enabling, community-based, or systems development services where appropriate. While seeking to foster this shift, FHS recognizes that some CHDs will need to provide some personal health care services in the future as true "safety net" activities, under the function of assurance. A simple way to conceptualize the shift, however, is to envision the movement of county staff out of the building, across the threshold of the health department, and into the community.

Movement into the community has been hindered to some degree by budgetary constraints discussed in Section III.B. Nonetheless, notable interaction occurred through community discussion groups convened as part of the FY 2004-05 MCH needs assessment process (reference #2). As well as seeking to promote interaction with the community, Family Health Services seeks to foster an increased emphasis on enabling services (for example [e.g.], case management or care coordination, described earlier in this section and under NPM #14 and State Performance Measures [SPMs] #10-11 ), population-based services (e.g., newborn screening, discussed under NPMs #1 and #12), and infrastructure-building services (e.g., capacity to collect, manage, and utilize data, discussed under SPM #7 and Health Systems Capacity Indicator [HSCI] #9a). Specific funding constraints on FHS are discussed in Section III.B.

## Special Challenges in Delivery of Services to CYSHCN

Addressing the service delivery needs of Alabama's CYSHCN presents special challenges. The State is predominantly rural in nature, with greater population concentrations surrounding 3 larger urban areas (Mobile, Birmingham, and Huntsville). In the rural areas, more risk factors exist that could potentially increase the percentage of CYSHCN among the general child population--such as higher levels of poverty and lower educational attainment. In addition, comprehensively meeting the needs of CYSHCN in the rural areas is more difficult due to transportation barriers and an inadequate supply of providers with specialized experience in treating more complicated health care issues. Pediatric subspecialists and allied health professionals with pediatric experience are primarily located in the larger urban areas, necessitating travel to access pediatric expertise. The State, however, has poor public transportation systems in general. Although private programs exist in some areas (Kid One Transport in Birmingham and surrounding areas) and reimbursements for transportation are provided through various sources (including Medicaid and CRS), the State lacks a solid infrastructure to meet the needs of citizens in all geographic locations. Thus, CRS continues to have an integral direct service role in the State's system of care for CYSHCN via its 15 community-based offices. Through the provision of multidisciplinary medical specialty clinics in over 15 locations in the State, as well as provision of community-based rehabilitation, support, and coordination services throughout the State, more CYSHCN have access to quality services within their home communities. Through CRS' memorandums of agreement with the two tertiary-level pediatric hospitals in the State, CYSHCN can access all or part of their medical care at these institutions while receiving community-based coordination, support, and follow-up by CRS staff. These public/private partnerships enable CRS to bridge gaps in the system of care, thereby increasing the State's capacity to address the health, social, and educational needs of Alabama's CYSHCN. Through its intradepartmental collaboration with VRS), CRS promotes the transition of youth with special health care needs, including Supplemental Security Income (SSI) beneficiaries, from school to work and to independence.

Due to consistent reductions and/or level funding from federal MCH Block Grant monies and State appropriations, significant budget shortfalls have faced the State CSHCN Program. As CRS is also responsible for adults and children with hemophilia and other bleeding disorders, the increased manufacturing costs for the production of clotting factor products and increased utilization in response to a shift in standard of care towards prophylactic treatment have caused concerns related to the long-term sustainability of the program at current funding levels. For the first time since 1991, CRS was forced to implement significant budget reductions resulting in cuts to services provided to CYSHCN and their families. Of necessity, the agency sought to reduce its budget for purchasing services for families by 1.5 million dollars in FY 2005. The incontinence supply (diaper) program was suspended effective October 1, 2004. Effective December 1, 2004, CRS suspended purchasing services for children whose family annual taxable income exceeds 250% of federal poverty guidelines. These children may still attend clinics and receive services, including care coordination, through CRS staff in their local district office. CRS eliminated the purchase of all services for children with heart diagnoses and the purchase of all replacement hearing aid batteries, standers, ramps, and patient lifts. Guidelines were established regarding the purchase of therapy services, which emphasized that therapy should be specific (goal oriented), time-limited, and focused. CRS reduced transportation reimbursement for families from 25 cents per mile to the Medicaid rate of 11 cents per mile. Funding to the medical genetics programs at UAB and the University of South Alabama (USA) was eliminated after the first quarter of the year. These decisions, although difficult, were made by a work group consisting of state office administrators, field supervisors, CRS medical consultants, and family representatives. Further reductions may be necessary if sufficient cost savings are not realized through these measures.

CRS has directed much effort toward informing families about changes in health-related resources and assisting them in accessing alternative resources to meet needs. Family Voices of Alabama sponsored a statewide letter writing campaign to lawmakers, providing families an opportunity to discuss the specialized needs of CYSHCN and to express concerns to their local legislators over the potential impact of budget cuts. Also, the ADRS Commissioner has led the agency in educating State legislators regarding the crucial role of ADRS, including all divisions, in meeting the needs of the

State's CYSHCN. Through the services provided by ADRS, CYSHCN are better able to reach their maximum potential in educational, vocational, and community pursuits. By communicating this benefit to legislators, the agency is hopeful in seeking additional funding.

## **B. AGENCY CAPACITY**

### **ADPH PROGRAM CAPACITY**

#### **ADPH: Fiscal Issues and Capacity**

The Title V Program has substantial capacity to provide services to--and promote and protect the health of--mothers, infants, children/youth, and pregnant women. To maintain such capacity, ADPH, including Family Health Services, must periodically adapt to budgetary constraints imposed by factors beyond the Department's control. Such factors, as well as the Department's adaptation to resultant budgetary constraints, have been chronicled in previous MCH reports/applications. For example, notable reductions in ADPH funding had occurred by FY 1999. These reductions were due to changes in the federal Home Health Care Program, an increase in the State costs of insurance coverage for State employees, and a legislated (but not totally funded) 8% cost-of-living raise for State employees in October 1998. This reduction in funding resulted in significant layoffs (about 1,400) in CHDs from October 1998 to September 1999 and a reduction in State funding provided by the State Health Officer to other FHS programs. Area-level staff, specifically the area Family Health Services Coordinator positions, were eliminated in January 1999, and the Area Nursing Directors assumed many of the Family Health Services Coordinator responsibilities. Though not at previous levels, ADPH funding stabilized by late FY 1999, and further massive layoffs have not occurred.

However, late in FY 2003, projected shortfalls in State revenue for FY 2004 caused the Department to critically review all funding sources, prioritize budget expenditures, and aggressively cut expenditures. As part of this process, the State Health Officer asked FHS to reduce FY 2004 projected expenditures of MCH Services Block Grant funds (MCH Title V funds) on FHS programs by \$1,600,000, compared to FY 2003. One purpose of these reductions was to increase MCH Title V support of CHDs, who faced inadequate local support and decreased availability of State funds. Such use of MCH Title V dollars supported local infrastructure, so that CHDs could continue serving the State's low-income maternal and child population.

Another, albeit overlapping, purpose was to set aside funds to sustain MCH services provided by State, public health area (PHA), and CHD staff--should State funds available to ADPH be further reduced. Such further reductions were quite conceivable, given the State's acute financial shortfall and marked uncertainty over measures that might be taken by the State Legislature. In addition to being asked to reduce projected expenditures of MCH Title V funds allocated for FHS programs, FHS was informed that State dollars previously available to support the State Perinatal Program and the Dental Program would no longer be available. Accordingly, the FHS's Director and Division Directors closely scrutinized projected expenditures for contracts, purchase orders, then-vacant positions, recently funded projects, and grants to other entities. Though the resultant decisions on cuts in projected expenditures were necessary and appropriate, the capacity of certain FHS programs was unavoidably diminished to varying degrees. What follows is a list of certain FHS programs and contracts affected by this \$1,600,000 reduction in FY 2004 projected (as of late FY 2003) expenditures of MCH Title V funds on FHS programs:

- 1) Community Development Specialist Program--FHS had embarked on this program in FY 2003 in order to support further involvement of county-level staff in promotion of community-based MCH initiatives. This support was provided through cooperative agreements between ADPH and selected PHAs, in which MCH Title V dollars funded 8 positions for conducting community health initiatives. The cooperative agreements were not renewed in FY 2004, ending this focused effort.

- 2) Abolishment of certain positions in 2 programs--FHS abolished the following 3 positions--the Oral

Health Branch's position for a fluoridation specialist and the Women's and Children's Health Division's 2 positions for nurses to perform quality assurance functions. Abolishing the fluoridation specialist position greatly diminished OHB's ability to promote water fluoridation and monitor existing water systems. By early FY 2005 FHS's budget could again fund this position, which is expected to be filled on June 13. The quality assurance function has been absorbed by FHS's Women's Health Branch and the WIC Division.

3) Programs with unfilled vacant positions--Due to resignations or promotions to positions outside FHS, the following positions became vacant before or during the FY 2004 budget reductions: 1 epidemiologist and 1 public health research analyst in the Epidemiology and Data Management Branch (Epi/Data Branch), 1 account clerk in the Administration Division, and 1 nurse in the Women's and Children's Health Division. Because funds previously allocated for these positions in FY 2004 were needed to sustain other programs, FHS decided not to fill these positions. Consequently, directors of the involved units must clearly prioritize tasks, leaving some very important, though perhaps less urgent, tasks undone. For example, as described in Section 1 of the State's 5-year MCH needs assessment report, certain needs assessment tasks are being postponed until FY 2006, when they will be conducted as part of ongoing needs assessment. If funds permit, FHS will seek to add 1.5 Epidemiologist full-time-equivalents, through contract and/or merit system hiring, in FY 2006.

4) The Uncompensated Maternity Care Project--Through this program, implemented in CY 2004 and discussed in Section III.A, MCH Title V funds had been used to help local communities design and maintain systems of care for maternity patients who could not pay for services. These patients were mainly Hispanic/Latino clients. The program was discontinued in FY 2004 in order to set aside funds for other MCH services. The termination of this program diminishes the Department's ability to promote systems of care for maternity patients who cannot pay for services.

5) Contract with ADRS--Through FHS, ADPH continues to contract with ADRS to administer services to CYSHCN, through CRS. As part of this contract, prior to FY 2004 ADPH had transferred about 35% of MCH Title V funds to ADRS. Fiscal constraints necessitated that, effective FY 2004, ADPH begin transferring only about 30% of MCH Title V funds to ADRS. (The amount transferred to ADRS was later increased to 32% of MCH Title V funds.)

6) Contract with Monsky Developmental Clinic--The Monsky Developmental Clinic serves CSHCN in the Montgomery, Alabama area. In FY 2003 FHS channeled \$173,000 in MCH Title V funds to this clinic. This amount was reduced by half in FY 2004, greatly diminishing the capacity of Monsky Clinic to serve children with special health care needs.

Some of the savings from the preceding measures were redirected in FY 2004 to sustain the State Perinatal Program and the State Dental Program, the latter of which is administered through the Family Health Service's OHB. Even with this redirection, these programs could not be sustained at previous levels. For instance, with the exception of the Monsky Developmental Clinic, FHS no longer channels funds toward clinics that follow infants discharged from neonatal intensive care units. (The consequences of discontinuing support for such clinics, from the viewpoint of a neonatologist, are described at the end of this update.) Additionally, as previously mentioned, OHB's ability to promote water fluoridation and monitor existing water systems has been greatly diminished. However, The State Perinatal Program and State Dental Program continue to provide crucial MCH services described elsewhere in this document. As previously explained, some of the savings in projected (as of late FY 2003) FY 2004 MCH Title V expenditures were reserved to cover unforeseen changes in the State's very uncertain fiscal situation. Accordingly, as of early May 2004, senior-level FHS administrators began consulting with the State Health Officer and ADPH's Public Health Administrative Officer regarding potential uses of unspent FY 2004 MCH Title V funds. One consequence of this consultation was that, by early FY 2005 ADPH began transferring 32% of MCH Title V funds to ADRS, which is still below the 35% that had been transferred prior to the FY 2004 budgetary constraints.

Additionally, fiscal constraints led to abolishment of 5 WIC positions in FY 2004: 3 for health services

administrators and 2 for administrative support assistants.

As stated in Section I.E, in June 2004 BFHS sought input from the State Perinatal Advisory Council (SPAC) and regional perinatal advisory councils. This process entailed distribution of a summary of key activities pertaining to the national and State performance measures to members of these groups, an offer to provide the entire pre-submission draft of the 2003 report/2005 application upon request, and an invitation to provide comments. A neonatologist (subsequently termed "respondent") from the northwest part of the State expressed serious concerns, via a telephone call and a follow-up letter, about the impact of budget cuts on "High Risk Clinics," which follow high-risk graduates of neonatal intensive care units. (In this context, "high risk" refers to an infant who is discharged from a neonatal intensive care unit, whose birthweight was less than 1,500 grams, and/or who is at risk of physical, social, or neurodevelopmental problems.) Since budget cuts, most of these clinics have closed their doors. From the perspective of the respondent (who is neither employed by nor receiving financial benefit from such clinics), the closure of High Risk Clinics entails a high cost in terms of dollars and in terms of medical homes. In the environment in which the respondent works, a graduate of a neonatal intensive care unit who was referred to a High Risk Clinic could be seen by at least 6 specialists during a single visit. Without such clinics, such an infant now requires from 3 to 8 appointments to receive the same evaluations that could have been done in a single appointment at a High Risk Clinic. Further, families "have to visit many offices and hospitals and radiology centers to continue the care of these fragile infants." Moreover, the respondent expects that the lack of a medical home, which would have been provided by a High Risk Clinic, will increase use of emergency rooms by the affected population. In sum, he anticipates that the closure of these clinics will increase the cost incurred by Medicaid in funding care for some of these infants and, as well, deprive many infants of a medical home.

#### Culturally Competent Care

ADPH seeks to provide culturally competent care that is appropriate for populations receiving the particular service being provided. For example, a component of ADPH's Pediatric Physical Assessment Course covers cultural factors and how these factors influence patient/family responses and care. This training is required by Medicaid for non-baccalaureate nurses who perform EPSDT assessments. The pediatric assessment pocket guide that is given to the nurses at the training has a section on cultural variations in family and health practices (Reference #3). Additionally, ADPH provides a refresher course for baccalaureate-prepared nurses who have not recently performed assessments. Though these nurses do not receive the aforesaid pocket guide, they receive a lecture and didactic information on cultural factors. Further, FHS's Newborn Hearing Screening Program's brochure, which is distributed by birthing facilities to all new mothers, has been translated into Spanish. With respect to public input, community discussion groups convened by FHS during the FY 2004-05 MCH needs assessment included 2 groups comprised of Hispanic/Latino individuals and 1 group comprised largely of Native Americans.

#### CRS PROGRAM CAPACITY

CRS has taken an active role in ensuring a statewide system of services that is comprehensive, community-based, coordinated, culturally competent, and family-centered. A discussion of efforts at both the State and community levels follows.

CRS has several ongoing State-level collaborative initiatives to address systems development for Alabama's CYSHCN, and provides leadership in policy-making and service provision for CYSHCN in the State. Functioning as a voice for CYSHCN, CRS works with DCA, discussed in Section III.A, through the State CPC to review information concerning children's services statewide. CRS also partners with an interagency group to implement an enhanced benefits package for CYSHCN through ALL Kids Plus, provided through SCHIP. Further, CRS is involved in EIS's Governor's Interagency Coordinating Council (ICC), which has developed policies and monitoring standards for service delivery, developed joint legislative budget requests, and shared data on infants and toddlers with disabilities. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinic Services and facilitates service planning via its advisory role regarding the unique needs of

## CYSHCN and their families.

CRS staff support community systems building through EIS's District ICCs and their involvement with the network of county-level CPCs facilitated by DCA. All divisions of ADRS play a key role in local and State CPCs. As CPCs are charged with assessing broad categories related to all children, CRS provides the voice for CYSHCN and their families on recommendations specific to this subset of the population.

Several mechanisms exist to coordinate health services for CYSHCN within community-based systems. CRS district offices function as powerful resource networks within their local communities, responding to numerous requests for information on CYSHCN. CRS has MOUs with the State's 2 tertiary-level pediatric hospitals to provide community-based care coordination, family support activities, and financial assistance to CRS-eligible children and their families receiving subspecialty care at these institutions. These agreements ensure that children are referred and receive appropriate services from both providers. Medicaid's Patient 1st Waiver has also enhanced the flow of information between primary and specialty care at the community level, through the assignment of all children, including those with special health care needs, to a medical home.

The coordination of health services with other services at the community level is facilitated in several ways. CRS offices are co-located with EIS and VRS in most locations, facilitating more coordinated services and smoother transitions for CYSHCN. Special education, social services, and family support services are brought together by the DCCs at the community level; this mechanism has increased collaboration regarding service coordination for other age groups as well. County-level CPCs address the coordination of a wide array of children's services, including primary, specialty, home health, and mental health services at the community level. CRS is the voice for CYSHCN on these councils.

CRS is one of 3 agencies responsible for a portion of early intervention services through the sponsorship of 16 EIS programs statewide. These programs provide a more coordinated, team approach to early intervention as opposed to the previous more piecemeal system, by which the 7 CRS districts provided case management services directly to eligible infants and toddlers and purchased related services (physical therapy, occupational therapy, speech therapy) via a vendor system. CRS State Office staff participate in the annual Provider Appraisal Review for these programs to ensure consistent quality and fiscal responsibility, provide technical assistance, and provide information to program coordinators on the benefits of referral to CRS for eligible infants and toddlers with special health care needs.

Through these various mechanisms, CRS has far-reaching influence on the State's service system at both State and community levels. As new challenges and opportunities present, CRS's mission and infrastructure, as detailed below, support a ready response.

The mission of CRS is to enable CYSHCN to achieve their maximum potential within a community-based, family-centered, comprehensive, culturally sensitive, and coordinated system of services. CRS is organized in 3 levels--State, district, and local--to provide a statewide community-based system of care that collaboratively identifies and utilizes resources while avoiding duplication of services. At the State level, administrative staff provide program direction through policies and protocols, staff resource development, program planning and evaluation, data analysis, quality assurance, technical assistance, and fiscal management. The State team also includes a specialty medical consultant, a pediatric medical consultant, the State Parent Consultant, the State Youth Coordinator, and the State Youth Consultant. Four State advisory committees (parent, medical, hemophilia, and youth), as well as local parent advisory committees that meet in every district office, ensure consumer and provider input into the program. Collaborative planning with public and private agencies occurs at the State level to develop and enhance systems of services for CYSHCN and their families. Mechanisms for systems development include interagency agreements, training/in-service activities, data sharing, task forces and committees, and State legislation.

The State is divided into 7 service districts for CYSHCN, each managed by a supervisor responsible



for personnel, service implementation and maintenance, and office operations. Fifteen local offices around the State provide community-based services to children and families through outpatient specialty medical clinics; care coordination activities; home, school, and community visits; and agency consultations. Specialty medical staff are recruited from the public and private sector and are credentialed by the CRS medical consultant. They may provide services in their home community or travel to CRS clinic sites in rural areas where specialty services are not otherwise available. County care coordinators, generally nurses or social workers, travel within their assigned counties to meet families, arrange services, and maintain working relationships with other service programs/providers. These coordinators also work to develop the State's system of care by identifying local providers with expertise related to CYSHCN and working with community groups on planning issues concerning CYSHCN. Care coordinators have access to a team of CRS specialists to deliver community-based care, education, consultation, or therapy. CRS staff members are mobile and not restricted by district boundaries in the delivery of services. Families are similarly unrestricted and may access services in any CRS office. Any State resident from birth to 21 years of age who has a special health care need is eligible for CRS services. Financial assistance and family participation are determined by the program's sliding fee scale. Families with incomes below FPL and Medicaid-enrolled children receive full assistance. SSI beneficiaries less than 16 years old are eligible for CRS services. Referrals for children evaluated for SSI are received in the State Office from the State Disability Determination Units (DDUs) in Birmingham and Mobile and processed to the appropriate local office, where families are contacted to offer CRS services, including care coordination. Special flyers with the State toll-free number and a listing of CRS services are distributed through the local offices of the Social Security Administration (SSA) and a CRS staff member provides an annual inservice on the CRS program for each local SSA office.

CRS operates 7 service programs to serve CYSHCN and their families. Services provided in each of these programs are paid for in full or in part by Title V funds. The 7 programs are:

- 1) Information and Referral--provision of information on resources available in the community, in the form of educational materials related to pediatric specialty health care, community resources, etc.
- 2) Specialty Clinical Services/Clinical Medical--clinics directed by physicians and staffed by multidisciplinary teams for provision of diagnosis, evaluation, treatment, and related services.
- 3) Specialty Clinical Services/Clinical Evaluation--physician-supervised clinics to provide functional evaluation and planning services by multidisciplinary teams.
- 4) Client/Family Education--provision of information to clients and their families that is necessary for carrying out prescribed treatment regimens and making informed choices about services that best meet their needs.
- 5) Care Coordination--arrangement of services to assist clients and families in identifying, accessing, and utilizing health and related resources to effectively meet their needs.
- 6) Parent Connection--provision of family-to-family support and information through State and local parent consultants, a parent-to-parent network, family resource centers, sibling support activities, and publication of the Parent Connection Newsletter.
- 7) Youth Connection--facilitates youth-to-youth connections, supports youth involvement in policy development and decision-making, and promotes transition services for youth with special health care needs to all aspects of adult life. The Youth Connection Program consists of a Youth Advisory Committee (YAC), a Youth Consultant, Teen Transition clinics, linkages to VRS, and a Youth News insert in the quarterly Parent Connection newsletter.

ADRS maintains a public website with information about the agency and services offered. The CRS pages are designed with the unique look and tag line as adopted by the program. This look matches other public awareness materials for the program and serves to increase the visibility of the State

CYSHCN Program to the general public. A link from the CRS pages provides consumers access to a directory of ancillary care providers for each CRS district.

## SOME STATUTES RELATED TO THE TITLE V PROGRAM

Salient legislation pertaining to the Title V Program includes the following:

- 1) CRS Statutory Authority--The State statutory authority for the CRS program is in Code of Alabama 1975 SS 21-3-1 et seq. The administrative responsibility for the program was given to SDE due to its administration of a State program for CSHCN prior to passage of the Social Security Act in 1935. The Alabama Hemophilia Program was created in Code of Alabama 1975 SS 21-8-1 et seq. and placed within CRS administratively. Code of Alabama 1975 SS 21-9-1 et seq. created ADRS by moving the former division, with all its component programs, out of SDE on January 1, 1995. The major impact of these legislative acts is that CRS is administratively under ADRS rather than ADPH and serves, in addition to CSHCN, adults with hemophilia and related bleeding disorders through the Alabama Hemophilia Program.
- 2) Alabama Perinatal Health Act--The Perinatal Health Act was enacted in 1980 in an effort to confront the State's high infant mortality rate. The statute established the State Perinatal Program (SPP) and the mechanism for its operation under the direction of the State Board of Health and SPAC, with the latter representing the Regional Perinatal Advisory Committees (RPACs). The RPACs make recommendations to SPAC regarding perinatal concerns. SPAC advises the State Health Officer in the planning, organization, implementation, and evaluation of SPP. SPP is based on the concept of regionalization of health care, a systems approach in which program components in a geographic area are defined and coordinated to ensure that pregnant women and their newborns have access to care at the appropriate level.
- 3) Child Death Review--Legislation creating the Alabama Child Death Review System (ACDRS) was enacted in 1997 and has a mandate to review all unexpected/unexplained deaths of children in Alabama from birth through 17 years (HB.26,97-893). Reviews include children who die from a vehicle accident, drowning, fire, sudden infant death syndrome (SIDS), child abuse, suicide, suffocation etc. Deaths from prematurity or birth defects, as well as deaths from terminal illnesses, are not reviewed by these teams. The purpose of these reviews is to identify trends in unexpected/unexplained childhood deaths, educate the public about the incidence and causes of these deaths, and engage the public in efforts to reduce the risk of such injuries and deaths. Funding for this program comes from the national settlement with the tobacco industry and will be disbursed through the Children First legislation described later in this section.
- 4) Alabama Act 98-611--This legislation supports development of the recently initiated Alabama Trauma Registry, which involves collection, storage, and subsequent manipulation of trauma-related data on a statewide level. The Head and Spinal Cord Injury Registry and Traffic Injury Registry, along with additional trauma elements, are incorporated into a centralized database managed by ADPH's Injury Prevention Division.
- 5) School Nurse Law Act 98-672--This act, passed by the Alabama Legislature in 1998, mandated a school nurse for each school district in FY 1999 and a school nurse for every 2,000 students by 2010.
- 6) SCHIP--See "Changes in the Health Care Environment," in Section III.A.
- 7) Children First--A major legislative event was the passage by the Alabama Legislature of the Children First Bill (in April 1999), which allocated some of the money the State would receive from the national settlement with the tobacco industry to various programs to improve the welfare of Alabama children. When tobacco settlement dollars come to Alabama they are deposited into the 21st Century Fund (\$95.8 million in FY 2001), where about 12% are used first for debt service on economic development bonds. Remaining tobacco dollars are then split between Children First (about 53%), Medicaid (about 35%), and Senior Services Trust Fund (1%). Money that comes to Children First is divided among 12 agencies for specific programs as instructed by law (Section 41-15B-2.2). Agencies

collectively receiving the bulk (about 79%) of Children First funds are SDE (22%), DHR (20%), the Department of Youth Services (17%), the Administrative Office of Courts, for use in provision of juvenile probation services (10%), and ADPH (10%). ADPH uses its portion of Children First funds (about \$6.2 million in FY 2003) to help provide health insurance to uninsured children (reference #4, Appendix C).

8) DCA--Legislation created this new State department, discussed in Section III.A, in 1999. In 2000 legislation was passed that expanded the powers and duties of DCA to include creating and maintaining a "repository for information" regarding children's programs in Alabama, reviewing budget requests, and reporting annually to the Governor and State legislature on the activities and expenditures of State and local agencies related to children. DCA will gather information for the purpose of acquiring additional funding for children. ADPH and ADRS, including both CRS and EIS, were specifically included in this legislation.

9) Graduated vehicle licensure--Legislation for graduated vehicle licensure was passed by both State legislative bodies by early April 2002, signed by the Governor in September 2002, and became effective in October 2002. For licenses issued during or after that month, restrictions apply to 16-year-old drivers and to 17-year-old drivers who have been licensed for less than 6 months. Under the legislation, restricted drivers cannot have more than 4 passengers, not counting their parents, in the car. Additionally, except under certain circumstances, they cannot drive between midnight and 6 A.M. unless accompanied by a parent, guardian or, with the consent of the parent/guardian, a licensed adult driver. The circumstances in which they do not need to have a parent/guardian or licensed adult designee of the parent/guardian with them are when the teenager is driving to or from work or a school or church event or driving due to an emergency.

10) Woman's Right to Know Act--The State Legislature passed the Woman's Right to Know Act in 2002, and the law went into effect in October 2002. Its purpose is "to ensure that every woman considering an abortion receives complete information on the procedure, risks and her alternatives." The act requires that ADPH create a printed informational booklet as well as an informational video tape. In accordance, ADPH's Bureau of Health Provider Standards drafted a pamphlet for distribution to abortion centers. A group of health care facilities and physicians who provide abortion services in the State challenged the constitutionality of the act and sought "a preliminary injunction or a temporary restraining order against its enforcement." The preliminary injunction or temporary restraining order requested in the aforesaid challenge was not granted, and the Woman's Right to Know Act remains in effect.

11) State's Office of Women's Health--This office was created with passage of State legislation in 2002 to educate the public regarding women's health; to assist the State Health Officer with identification and prioritization of women's health issues and concerns relating to the reproductive, menopausal, and postmenopausal phases of a woman's life; to assist the State Health Officer in coordination of services to address these issues and concerns; to serve as a clearinghouse and resource for information regarding women's health data, strategies, services, and programs; and to collect, classify, and analyze relevant research information and data concerning women's health. This office is located in ADPH's Office of Professional Services.

## **C. ORGANIZATIONAL STRUCTURE**

DCA, DHR, MHMR, and Medicaid are all cabinet-level agencies, and the Governor directly appoints their commissioners. ADPH, SDE (which includes the State's 2 disability determination units), and ADRS are not cabinet-level agencies. As their respective boards appoint the heads of these 3 departments, they have experienced more stability and continuity in their leadership, enabling a more consistent program direction. However, compared to agencies having a commissioner appointed by the Governor, ADPH and ADRS have relatively less access to the Governor. Linkage for communication and organizational cooperation exists on 2 levels for ADRS and ADPH. The State Health Officer and the ADRS Commissioner work together on matters of mutual concern, as do the CRS and FHS Directors. Staff members from CRS and BFHS meet quarterly to discuss programmatic

and administrative issues pertinent to MCH services. ADPH continues under the direction of the State Board of Health and is not under the direct authority of the Governor. FHS is a major unit within ADPH, and CRS is a major division within ADRS. Current organizational charts for ADPH, BFHS, ADRS, and CRS are in Appendix D, which is available as described in the first paragraph under Section III.A.

#### ADPH'S ORGANIZATIONAL STRUCTURE

As described in previous MCH reports/applications, FHS has reorganized several times in recent years, in order to accommodate staffing changes and enable the Bureau to efficiently respond to public health challenges and opportunities emerging at various times. Throughout recent years, 4 divisions have comprised the major units of FHS: the Administration Division, the WIC Division, the Professional Support Division, and the Women's and Children's Health Division. FHS is administered by the Bureau Director and, under his oversight, the Bureau Deputy Director, with input from the Bureau Management Team. The Bureau Management Team consists of the Bureau Director, Bureau Deputy Director, each Division Director, and each Division Deputy Director.

Due to shortfalls in State revenue for FY 2004 that were projected as of late FY 2003 (discussed in Section III.B), several changes occurred in FHS's organization. These changes mainly affected the Professional Support Division and the Women's and Children's Health Division. The Professional Support Division was directly affected by the fiscally related decision not to renew the cooperative agreements with several PHAs in FY 2004. The purpose of these agreements had been to support MCH community health initiatives. With these agreements no longer in force, the Professional Support Division's Community Development Program was dissolved as a separate entity and removed from the Bureau Organization Chart. Fiscally related decisions directly impacted the Women's and Children's Health Division in several ways. This division's Quality Assurance Branch was discontinued in early FY 2004, and its functions were absorbed by the Children's Health Branch and the WIC Division. In the Women's Health Branch, the Alabama Unwed Pregnancy Prevention Program was phased out, effective June 30, 2004. Further, the Uncompensated Maternity Care Project was phased out in early FY 2004, and responsibility for the maternity program was assumed by the Director of SPP.

Further changes in FHS structure that were unrelated to fiscal constraints occurred in FY 2004. Again, these changes pertained to the Professional Support Division and the Women's and Children's Health Division. The Oral Health Branch (OHB), which had previously been located as an adjunct to the Bureau Director, was moved to the Professional Support Division. Also within that division, the State Systems Development Initiative Project (SSDI) was added to the FHS Organization Chart, within the Epi/Data Branch where SSDI had been located for several years. In the Women's and Children's Health Division's Children's Health Branch, a position for an additional Newborn Screening Coordinator, to focus on expanding the newborn screening profile as discussed in Section IV.C (under NPM #1), was added to the Newborn Screening Program. Also in that branch, responsibility for infant death review was removed from the Child Death Review Program, since responsibility for fetal and infant mortality review (FIMR) had previously (in FY 2002) been transferred to SPP.

Since the above changes went into effect the Women's and Children's Health Division has had 2 branches, each with multiple units, while remaining divisions have had 3 branches each. Further description of each division, as organized from April 2005 through the present (May 2005), follows. The Administration Division consists of the Financial Management, Contract Management, and Personnel Management Branches. The WIC Division consists of the Vendor Management, Data Management, and Nutrition Services Branches, with the WIC Training Clinic located in the Nutrition Services Branch. The Professional Support Division consists of the Consultant Branch, which includes the Social Work Program and the Nursing Program; the Epi/Data Branch, which coordinates preparation of MCH reports/applications, conducts MCH needs assessment, and administers the SSDI Project; and the Oral Health Branch. The Women's and Children's Health Division consists of the Women's Health Branch and the Children's Health Branch. The Women's Health Branch includes the Family Planning Program, through which the Plan First Program is administered, the State Perinatal Program/Maternity Program, the Smoking Cessation Program, and the Breast and Cervical

Cancer Program, which is subsequently discussed. The Children's Health Branch includes the Newborn Screening Program, Newborn Hearing Screening Program, Lead Program, Healthy Childcare Alabama Project, Child Death Review, Abstinence Program, and School/Adolescent Health Program. Ten percent of the Director of the Healthy Childcare Alabama Project's time is allocated to Adolescent and School Health. (The lack of a full-time adolescent health coordinator is discussed in Part 4 of the FY 2004-05 MCH Needs Assessment Report.) FHS's Administration Division performs the major financial functions for all 4 of the Bureau divisions, and WIC pays for 2.18 FTEs in the Administration Division.

A major addition to FHS occurred in March 2005. At this time the Breast and Cervical Program, previously located in the Department's Bureau of Health Promotion and Chronic Disease (HPCD), was administratively relocated to FHS, where it is located in the Women's Health Branch. The relocation of this program brought 4 additional central-office positions to FHS, 11 PHA Screening Coordinator positions (1 for each PHA), and 2 out-stationed staff positions. Decisions on how to most efficiently and effectively implement the Breast and Cervical Cancer Program, which includes reviewing responsibilities and administrative locations of each of the program's staff members, are in progress. Administrative functions of the program are currently coordinated by the Director of Plan First, located in the Women's Health Branch.

One temporary variation regarding the aforesaid organizational structure is that FHS's Deputy Director is Acting Director of the Personnel Management Branch for a time, although that branch is located in the Administration Division. The reason for this variation is to allow staff of the Administration Division, which underwent a change in directorship in April 2005, sufficient time to focus on pressing budgetary and reporting issues. Oversight of personnel transactions will be returned to the Director of the Administration Division as soon as feasible.

#### **ADRS'S ORGANIZATIONAL STRUCTURE**

ADPH contracts with CRS, a division of ADRS, for services to CYSHCN. CRS has administrative responsibility for the State Title V CSHCN Program, and the Alabama Hemophilia Program. The Alabama Board of Rehabilitation Services, whose members are appointed by the Governor, oversees ADRS, which consists of four major divisions: EIS, CRS, VRS, and the State of Alabama Independent Living Program (SAIL). The current chairperson of the Board is a parent of young adults with special needs.

Cary F. Boswell, EdD, has been the ADRS Assistant Commissioner for CRS since January 1, 2002. Supervision of the 7 CRS district supervisors is directly under the CRS Assistant Commissioner. Dawn Ellis is the CRS Assistant Director, responsible for overseeing the day-to-day operations in field services, supervising the State Pediatric Traumatic Brain Injury (TBI) Coordinator, and supervising the program specialists for social work, nursing, policy, and MCH occupational therapy. David Savage is the State Supervisor for Professional Services, responsible for all other program specialists, training, and public awareness. Other administrative staff include the State Parent Consultant, the State Youth Coordinator, the State Youth Consultant, the Hemophilia Coordinator, a Patient Accounts Manager, and program specialists for each discipline. Positions for the Nutrition and Physical Therapy Program Specialists remain vacant. Current organizational charts for ADRS and CRS are in Appendix D, which is obtainable as described in Section III.A.

## **D. OTHER MCH CAPACITY**

#### **ADPH'S OTHER CAPACITY**

Pertinent cost-center data provided by ADPH's Bureau of Financial Services were used to estimate the number of ADPH FTEs devoted to serving Title V populations in Alabama. FTEs reported here are NOT limited to those paid for by Title V funds, because using only Title V cost centers notably underestimates the number of FTEs devoted to serving Title V populations. Excluding WIC cost centers, 270.9 ADPH FTEs can be identified as having served Title V populations in FY 2004. Of these 270.9 FTEs, 83.9% were at the county level, 2.0% at the PHA level, and 14.0% at the State level. Positions that each accounted for more than 5.0% of the 270.9 FTEs were: social workers

(49.4%); nurses, nurse practitioners, or midwives (31.4%); and administrative support assistants (10.2%).

If FTEs paid for by WIC are added to the aforesaid 270.9 FTEs, a total of 519.4 ADPH FTEs can be identified as having served Title V populations in FY 2004. Of these 519.4 FTEs, 85.0% were at the county level, 2.8% at the PHA level, and 12.1% at the State level. Positions that each accounted for 5.0% or more of the 519.4 FTEs were social workers (25.7%); administrative support assistants (24.9%); nurses, nurse practitioners, or midwives (23.5%); nutrition specialists (13.6%); and aides (5.3%).

The relative predominance of social worker FTEs is consistent with ADPH's increasing involvement in care coordination, discussed in multiple places in this document. In FY 2006 FHS staff will further explore ADPH cost centers to ascertain whether some services (such as immunizations) being provided to Title V populations are not being captured with our current methods for estimating FTEs devoted to serving Title V populations.

Brief biographies of selected key Title V personnel in BFHS follow.

Thomas M. Miller, MD, MPH, FACOG, FHS's Director, has been with ADPH since 1987. His varied roles as clinician, consultant, and Assistant State Health Officer for PHA V have particularly qualified him to serve as Bureau Director--a role he assumed in 1993. Additional experience includes work as an obstetrics/gynecology clinician in the private sector (before joining ADPH) and occasional labor and delivery coverage for the Montgomery County Maternity Waiver Program and for a private practitioner. He is a member of the Medical Association of the State of Alabama, a fellow of the American College of Obstetricians and Gynecologists (ACOG), and a member of the Alabama Section of ACOG, where he has been a Board member since 1992. Academic credentials include studies in medicine and public health.

Chris R. Haag, MPH, Deputy Director of FHS, Title V Director, and Director of the Professional Support Division, worked in the Madison CHD in Alabama for 2 years, where his duties included direction of health education activities and outreach services. He joined FHS in 1989 to direct an adolescent pregnancy prevention project. After the completion of that project, Mr. Haag held various positions with FHS, including Director of the Administration Division. Academic credentials include studies in education and public health. Mr. Haag has been Deputy Director of FHS and Director of the Professional Support Division for several years, and assumed the position of Title V Director in March 2005. This position had previously been held by Dr. Miller, who asked Mr. Haag to assume the position so that Dr. Miller could devote more time to his activities as Collaborative Physician for CHD nurse practitioners.

Sherry K. George, BS, MPA, Director of the Bureau's Division of Women's and Children's Health, has been with the Bureau since 1975. During this time she has become familiar with issues concerning perinatal health, child health, and family planning; visited many CHDs; and developed excellent working relationships with health professionals around the State. Academic credentials include studies in business management and public administration.

Dianne M. Sims, BSN, RN, who became Assistant Director of the Women's and Children's Division in March 2000, has been with ADPH since 1981 and joined BFHS in 1999. Her experience includes serving as a public health nurse and administrator at the county, area, and State levels. Previous positions include those of family health services coordinator, staff development coordinator, and acting director of Program Integrity. Academic credentials include studies in social work, nursing, child development, and early childhood education.

Charlena M. Freeman, LCSW, Assistant Director of the Professional Support Division, brought 20 years of medical social work experience when she joined the Bureau in 1996. Academic credentials include advanced degrees in social work and counseling.

Stuart A. Lockwood, DMD, MPH, Director of OHB, joined the Bureau in 2001. Dr. Lockwood practiced dentistry in Alabama for 4 years before earning an MPH with a double major in dental public health and oral epidemiology. Prior to joining the Bureau, he worked for 12 years with the U.S. Centers for Disease Control and Prevention (CDC) in the Division of Oral Health. A diplomate of the American Board of Dental Public Health, Dr. Lockwood was also the director of the Dental Public Health residency program at CDC.

Dan Milstead, BS, MBA, assumed acting directorship of the Administration Division in April 2005. Mr. Milstead joined ADPH in January 1989 as Director of the WIC Division's Financial Management Branch. In this position he was responsible for all of WIC's accounting and reporting requirements with the United States Department of Agriculture's Food and Nutrition Services. In 1998 Mr. Milstead transferred to the Bureau of Financial Services to be the Director of Third Party Collections; in this capacity he managed the Department's billing operations and distribution of funds. In July 2000 he returned to FHS as Director of the WIC Financial Management Branch. In 2003 his position with the WIC Division was incorporated into the Administration Division, where he was responsible for the WIC Program and Family Planning.

Gene Hamrick, RN, EdD, assumed the then-new position of Director of SPP in January 2001. Dr. Hamrick came to the Bureau with 9 years of experience as a State-level health education administrator. Additionally, she has 12 years experience in nursing education, including 5 years as university-level faculty. In collaboration with the FHS Director, other FHS staff, and SPAC, Dr. Hamrick plays a key role in developing strategies to improve public awareness of the causes and prevention of infant deaths, revitalizing the State's regionalized system of perinatal care, and improving women's health through the perinatal continuum. While continuing as Director of SPP, Dr. Hamrick assumed responsibility for the Maternity Program in early FY 2004.

Anita Cowden, MPH, DrPH, Director of the Epi/Data Branch, has been located at ADPH since 1989 (including 2 years as a CDC assignee). Dr. Cowden joined the Bureau in 1998 and coordinates MCH reports/applications and Bureau MCH needs assessment activities. Her masters-level studies concentrated in MCH; and her doctoral-level studies concentrated in epidemiology first, statistics second, and MCH third.

#### CRS'S OTHER CAPACITY

CRS maintains a multidisciplinary emphasis at district and State office levels. Currently there are 221.65 FTEs in the field: 7 district supervisors, 5.75 physical therapists (PT), 7 nutritionists, 6 speech-language pathologists (SLP), 8 audiologists, 8.9 parent consultants, 32 nurses, 50 social workers, 1 occupational therapist (OT), 1 rehabilitation counselor, and 95 administrative support assistants (ASA). There are 8 budgeted vacancies: 2 PTs, 1 nurse, 1 OT, 1 nutritionist, 1 audiologist, 1 district supervisor, and 1 ASA.

The State Office has 13.5 and 4.75 FTEs with administrative and clerical duties, respectively. Administrative staff includes 1 special educator, 2 social workers, 2 nurses, 2 SLPs, 1 nutritionist, 1 rehabilitation counselor, 1 patient accounts manager, 1 parent consultant, 1 audiologist, 1 OT, and a .5 FTE youth consultant. There are vacancies for 1 ASA, a nutrition program specialist, a PT program specialist, and a TBI Coordinator.

Key senior administrative staff of CRS includes the Assistant Commissioner, the Assistant Director, and the State Supervisor for Professional Services. The MCH Program Specialist (formerly Grants Management Specialist) is responsible for planning, evaluation, and data analysis. Biographical information on persons in these positions follows.

Cary F. Boswell, EdD is the Assistant Commissioner of ADRS and Director of CRS. His background includes 27 years of experience in special education, supported employment, and transition initiatives. He was formerly the ADRS State Coordinator of Transition from School to Work Programs. He served on Alabama's Special Education Action Committee Board of Directors, the Alabama Council for Developmental Disabilities, the SDE's Special Education Steering Committee, the SDE's Special

Education State Transition Task Force, and the Alabama Higher Education and Disability Board of Directors. Academic credentials include an undergraduate degree in business administration and graduate degrees in special education with emphasis in mental retardation and program administration.

Dawn E. Ellis, RN, MPH is the CRS Assistant Director, having assumed this position in January 2002. Her background includes experience in pediatric nursing and administration, including 12 years in neonatal intensive care, 3 years as an early intervention specialist, 4 years as a CRS district supervisor, and 4 years as the grants management specialist. She is a member of the American Public Health Association and the National Rehabilitation Association. Academic credentials include an undergraduate degree in nursing and a graduate degree in public health-MCH.

David H. Savage, BA, MSC is the CRS State Supervisor for Professional Services. His experience includes 27 years as a speech-language pathologist in educational and rehabilitation settings. His expertise includes staff training, quality assurance, and augmentative communication technology. He is a member of the American Speech-Language and Hearing Association and the Speech and Hearing Association of Alabama. He has served on the Alabama Board of Speech Pathology and Audiology. Academic credentials include undergraduate and graduate degrees in speech-language pathology.

Julie Preskitt, MS, OT, MPH is the MCH/OT Program Specialist. Her experience includes 7 years of high-risk follow-up, with 5 years of service provision to CYSHCN in pediatric hospital and early intervention settings. She is a member of the American Occupational Therapy Association and the Alabama Occupational Therapy Association. Academic credentials include undergraduate degrees in biology and occupational therapy and graduate degrees in occupational therapy and public health-MCH.

During FY 2004, there were 3 changes in the CRS State administrative staff. Following resignations, the Audiology Program Specialist was replaced internally by an audiologist from a CRS district office, the SLP Program Specialist was replaced externally by a former school system therapist, and the PT Program Specialist position remains vacant.

Through a partnership with United Cerebral Palsy (UCP) of Mobile, CRS employs 12 parents of CYSHCN as Local Parent Consultants (LPCs). UCP employs and supervises the LPCs, provides insurance and benefits, and supports State and Local Advisory Committee activities. A State Parent Consultant, based in the State Office, advises in collaborative inter-agency efforts, recruits additional parent participation, facilitates the State Parent Advisory Committee, coordinates the parent-to-parent network, and publishes the Parent Connection.

## **E. STATE AGENCY COORDINATION**

Coordination of the Title V Program with programs or entities specifically mentioned in the Guidance (reference #5, in Appendix C) for this section occurs in the context of FHS and CRS seeking to accomplish their respective missions and identify priority MCH needs, rather than under a particular plan to coordinate with specific programs. Since FHS administers the Title X Family Planning Grant and WIC, coordination with these 2 entities is built into FHS's organizational structure and internal collaborative mechanisms. Similarly, CRS and VRS are major divisions of ADRS, facilitating collaboration between the Title V Program and VRS. With respect to identification of Medicaid-eligible infants and pregnant women--through SCHIP, discussed in Section III.A and under NPM #13, ADPH and Medicaid collaborate to identify Medicaid-eligible infants and pregnant women and help with their applications for Medicaid coverage. With respect to SSA, as discussed in Section III.B, SSI beneficiaries less than 16 years old are eligible for CRS services; some ways that CRS coordinates with SSA are also discussed in Section III.B. CRS's collaboration with SSA through the DDUs and CRS's involvement with families are discussed later in this section.



FHS and CRS have collaborated via interagency meetings that are held 3 times a year and partnership on such tasks as preparing the MCH reports/applications and conducting the 5-year MCH needs assessment. A description of some of the collaborations in which each organization is involved follows.

#### ADPH COORDINATIONS/COLLABORATIONS

A description of certain collaborations (some of which are discussed elsewhere in this document) involving external groups follows. Unless otherwise stated, the collaborations began prior to FY 2004 and are expected to continue in some form through FY 2006.

##### FHS's Collaborations with Entities Outside of ADPH

Women's Health Branch staff collaborate with many statewide and community groups and governmental and private organizations to address various issues, such as with: the Alabama Chapter of the March of Dimes (AMOD) on the March of Dime's campaign to reduce the prevalence of prematurity (see NPM #15); Medicaid on an 1115(a) Family Planning Waiver (see Section III.A), SPAC to convene quarterly meetings with SPAC and to promote a strong regionalized system of perinatal care (see NPM #17), and regional FIMR teams to review infant deaths (see State Performance Measure [SPM] #7). (NPMs and SPMs are respectively discussed in Sections IV.C. and IV.D.)

The aforesaid collaboration with AMOD to reduce the prevalence of prematurity began in October 2002, when SPP partnered with AMOD to begin the March of Dimes campaign in Alabama. The planning phase of the partnership continued through December 2002. In January 2003 press conferences were simultaneously held in the State's 5 perinatal regions to announce the campaign on prematurity. RPAC members and AMOD volunteers presented the 2 campaign goals: to 1) increase public awareness of the problems of prematurity to at least 60%, and 2) decrease the rate of preterm birth in the U.S. by at least 15%. Target audiences for the campaign were the general public, pregnant women, and health care providers. The partnership is ongoing. For instance, in FY 2004 the Director of FHS, the Director of SPP, and several other FHS staff attended the "Advocacy Day at the State Capitol" press conference--convened by AMOD in partnership with VOICES for Alabama Children, the Gift of Life Foundation, and the Alabama Hospital Association--to support the conveners' call for full funding of Medicaid.

Additionally, Women's Health Branch staff collaborate with 1 of the 5 major perinatal referral hospitals to address the need for family planning services for a targeted high risk population. Linkages to services are provided for mothers of infants who are admitted to the hospital's neonatal intensive care unit. These women are at high risk for repeated poor outcomes of pregnancy. ADPH contracts with the hospital for their staff to provide family planning counseling and referral to Plan First providers and care coordinators. The intent of the project is to reduce the occurrence of unintended pregnancies and of infant deaths in the targeted population.

Child Health Branch staff collaborate with several entities, such as with: local child death review teams to implement ACDRS (see SPM #7), delivery hospitals to assure that newborns receive appropriate biochemical and hearing screening (see NPMs #1 and #12), SCHIP and Medicaid to promote enrollment of eligible infants and children in ALL Kids and Medicaid (see NPM #14), and, as a member of the Department's State Suicide Prevention Task Force, with multiple organizations to prevent suicide. Several members of the Child Health Branch are members of the Alabama Partnership for Children's Parenting Kit Committee and the Covering Kids and Families State Coalition. The Parenting Kit Committee recently revised and updated the Parenting Video, which is part of a kit given to mothers of newborns. The kit offers immediate access to information and resources regarding infant growth and development and care of infants. Covering Alabama Kids and Families, a statewide organization to promote health insurance coverage for children and adults in Alabama, is discussed under NPM #13.

In the summer of 2004, the Alabama Integrated Nutrition Education Partnership, which included WIC nutritionists, combined with the Alabama Obesity Task Force to work on a statewide plan to reduce

the risks of obesity and subsequent health-related problems due to obesity. Various subcommittees will work throughout the coming years to implement strategies to educate Alabamians on obesity issues.

Further, FHS convened the MCH Needs Assessment Advisory Group in January 2005 as part of the FY 2004-05 MCH needs assessment process. Through this advisory group, FHS collaborated with many persons from other agencies and organizations, with ADPH staff located outside of FHS, with out-stationed FHS staff, and with several health care consumers. (More information on the MCH Needs Assessment Advisory Group is provided in Section 1 of the State's FY 2004-05 MCH Needs Assessment, which is expected to be submitted via e-mail, per federal guidance.) Additionally, staff from FHS, CRS, Medicaid, UAB School of Public Health's MCH Department, UAB's Civitan Center, and TCHA's Pediatric Pulmonary Center meet 3 times a year to keep abreast on activities of common concern and to plan for coordinated initiatives affecting children. Moreover, 2 FHS staff members (respective Directors of the Child Health and the Epi/Data Branches) serve on the UAB Pediatric Pulmonary Center's Advisory Committee.

#### FHS's Collaborations with Other Department Entities

Many collaborations occur within FHS and among FHS staff and other ADPH staff. For example, Family Planning staff collaborate with many ADPH units/programs at the State and local level to coordinate projects and provide input/technical assistance on family planning. For instance, they collaborate with the Bureau of Disease Control's Sexually Transmitted Diseases Division and the Bureau of Clinical Laboratories (BCL) on the Title X Infertility Prevention Project; with the Department's Center for Health Statistics (CHS) on the Title X Regional Network for Data Management and Utilization Project; and the Public Health Nursing Section on Title X Training activities. FHS staff continue to provide administrative and programmatic support of CHDs and to participate in monthly meetings of ADPH Area Nursing Directors, Area Social Work Directors, and Area Administrators to share information and offer technical assistance. Additionally, WIC staff hold bimonthly meetings with the Nutrition Area Coordinators to provide updates on policies and procedures and provide information about technical assistance. As well, FHS continues its commitment to ensuring that children and women of childbearing age receive adequate treatment for phenylketonuria (PKU). Persons who cannot afford to purchase the necessary food items for managing the condition can choose from 9 medical foods for treatment of PKU. Moreover, Epi/Data Branch staff collaborate with persons from FHS and other Department units when preparing the MCH reports/applications.

As previously stated, the MCH Advisory Group convened in January 2005 included ADPH staff from outside FHS. These staff included several central-office staff members, several PHA staff members, and 1 person from a CHD. (Several invited CHD staff did not attend.) Additionally, in FY 2004 certain area- and county-level staff, as well as out-stationed State-level staff, helped with the FY 2004-05 MCH needs assessment. For instance, Social Work Directors or their designees from each PHA provided a list of potential recipients for the MCH Organizations Survey conducted in early CY 2004. Further, 14 county-level, area-level, or out-stationed State-level staff facilitated or helped facilitate 1 or more community discussion groups in early CY 2004.

In early FY 2005 the Director of FHS began devoting substantially more time to his continuing role as Collaborative Physician for all CHD-employed nurse practitioners, all of whom work in the area of women's health. The role of Collaborative Physician includes ongoing review and revision of protocols used by the nurse practitioners, training of nurse practitioners, assurance that protocols are followed, provision of consultation for situations not covered by the protocols, and other activities assuring the provision of appropriate, high quality services by nurse practitioners. As part of this effort, the Professional Support Division's Consultant Branch planned and convened a training event for CHD nurse practitioners, held in January 2005. Attendance at this event was mandatory for all CHD-employed nurse practitioners. The Director of FHS was one of the presenters at this event. Per informal feedback, the training was viewed by attendees as being quite successful, pertinent, and useful.

### ADPH Collaborations Described Elsewhere

Other collaborations are discussed in appropriate places throughout this report. Further, many other internal and external partnerships and collaborations in which FHS is involved are discussed in Section 2 of the previously referenced report of the State's FY 2004-05 MCH Needs Assessment. Only 4 of the collaborations discussed there are listed below (see the report of the State's FY 2004-05 MCH Needs Assessment for a full discussion.):

- 1) Ongoing membership of FHS's Director on the Advisory Consortium for the Birmingham-based Healthy Start Program.
- 2) In FY 2004, teaming of ACDRS staff with the Birmingham and Mobile Healthy Start Projects to fund hospital-based parent education programs on shaken baby syndrome.
- 3) Ongoing collaboration between FHS's Healthy Child Care Alabama Project and HPCD's Cancer Prevention Program, to teach the Sun Safety Program to children attending child care centers, the children's parents, and the providers of child care.
- 4) Ongoing partnership of FHS's WIC Division with the Health Department's Bureau of Communicable Disease's Immunization Division to provide "Golden Books" to mothers who bring their child's immunization record when coming for WIC certification or recertification. This is a way that the WIC Division participates in the national WIC Healthy Children Ready to Read Initiative, and may help the Immunization Division update their immunization registry.

### CRS COLLABORATIONS/COORDINATIONS

CRS has ongoing coordination with State and federal programs that strengthen the overall Title V program. The placement of CRS as a division within ADRS facilitates coordination of program planning and service delivery with other divisions, including EIS, SAIL, and VRS. EIS and VRS staff members are co-located with CRS staff in most locations throughout the State. Implementation of a transition plan for clients from CRS to VRS for vocational guidance is a priority focus for those clients for whom this is appropriate. CRS sponsors 16 Early Intervention programs statewide and continues active participation on the Governor's ICC and subcommittees and District Coordinating Councils (DCCs).

Collaborations also exist between CRS and various agencies for transition planning for CRS clients to the community and other post secondary education opportunities in cases where the clients may not choose vocational pursuits. VRS staff continue to collaborate with CRS in the ongoing development of a comprehensive statewide system of services for children and youth with TBI and in the implementation of the ADRS Continuum of Transition for Youth with Special Health Care Needs. Interagency agreements are in place for planning service delivery between ADRS and the Alabama Institute for Deaf and Blind, Head Start, the Department of Youth Services, and local education agencies for transition services.

CRS serves as a member of the State Newborn Hearing Screening Advisory Committee. This group meets once a year to provide input to ADPH, the lead agency in Alabama for the Universal Newborn Hearing Screening Program. Member agencies meet throughout the year as the State Early Hearing Detection and Intervention Committee to address ongoing State needs.

CRS supports Family Voices and VOICES for Alabama's Children. The CRS State Parent Consultant and the parent of a child enrolled in CRS together function as the State Family Voices Co-coordinators and the Region IV Family Voices Co-coordinators. CRS also supports the Alabama Governor's Youth Leadership Forum, an annual leadership and career skills training opportunity for Alabama high school youth with disabilities.

CRS is the lead agency in planning to meet the Healthy People 2010 objectives for CYSHCN. Workgroups have been formed around each of the 6 objectives for CYSHCN and are chaired by a colleague from outside the agency. CRS State Office staff members serve as liaisons to these groups and assist in the facilitation of quarterly meetings addressing planning and implementation of activities

and strategies to meet the objectives. Families of CYSHCN, youth, and representatives from other agencies are active participants in these workgroups. Individual workgroup action plans, including goals and action steps, are consolidated into an overall Alabama Action Plan to meet the 2010 objectives for CYSHCN. Activities will be ongoing over the next several years and the plan is updated as steps are completed and new objectives are set.

CRS is committed to participation in many State-level collaborative planning efforts affecting CYSHCN. CRS serves on the State and local CPCs, as well as on the State Head Start Disability Advisory Committee to provide guidance in accessing health, education, and welfare service systems. Other State-level systems development councils on which CRS participates include SPAC and the State Multi-Needs Child Task Force. Other key agencies involved with most of these councils include Medicaid, SDE, and MHMR. The CRS State Parent Consultant, CRS Local Parent Consultants, and CRS families participate on a variety of interagency committees and task forces, such as Healthy People 2010 workgroups, State Improvement Grant Taskforce on Recruitment, Preparation and Retention through SDE, UAB Civitan International Research Center Consumer Advisory Committee, the Special Education Action Committee Advisory Group, Olmstead Core Workgroup, Newborn Screening Task Force, Oral Health Coalition, Arthritis Coalition, Individual & Family Support Councils, Northeast Alabama Safe Kids Steering Committee, Family to Family Health Information Council, Alabama Respite Resource Network, a local UCP Board, and the Statewide Technology Access and Response Advisory Committee.

As mentioned in the preceding discussion of State-level collaborations, CRS participates in the Oral Health Coalition. The purpose of CRS's involvement with this coalition is to highlight access to care issues for CYSHCN whose disability may be a barrier to receiving routine and specialized dental care. This organization consists of some 31 public and private agencies and groups, with its stated purpose "to ensure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well-being of the child." A CRS staff member participated in and served as a presenter for the FY 2004 Alabama Dental Summit. With the completion of the initial Robert Wood Johnson grant funding, the Oral Health Coalition continues project activities, develops materials about prevention and intervention for lawmakers, policy-makers, and the general public, and disseminates dental awareness kits through alternative methods and funding sources. Future planning includes convening a subcommittee, to include a pedodontist and an orthodontist, to promote improved dental outcomes for CYSHCN. CRS continues to integrate dental health initiatives for CYSHCN into the program.

CRS partners with Medicaid in various ways. Although EPSDT services are now the responsibility of the primary care provider for all children under Medicaid managed care arrangements, CRS coordinates services with the medical home to ensure access to specialty care and related services through Medicaid funding for all CYSHCN served by the program. CRS continues its interagency agreement with Medicaid to provide Children's Specialty Clinic Services throughout the State, which enhances access to services for Medicaid recipients. CRS serves as the reviewer of all requests for Medicaid funding for augmentative communication devices and power wheelchairs. CRS serves in an advisory role to Medicaid for program and policy decisions likely to affect CYSHCN and served as a voice for this population in the planning for the new waiver for PCCM, Patient 1st (discussed in Section III.A).

CRS has a long history of collaboration with the Alabama Easter Seal Society to enhance services for CYSHCN through community rehabilitation centers and Alabama's Special Camp for Children and Adults (Camp ASCCA), a year-round camp facility for children and adults with disabilities. CRS staff members volunteer their time to provide their specialized skills for various camps, and the agency supports camps for children with hemophilia through public awareness and the provision of educational materials and self-infusion teaching kits. CRS also has an extensive partnership with UCP, including the employment of local parent consultants and public awareness for Camp Adventure, a camp for children and youth with disabilities.

CRS collaborates with SSA through the DDUs in Birmingham and Mobile for serving SSI beneficiaries

below 16 years of age. CRS staff provide fact sheets with contact information and an annual in-service training to SSA offices located in the various districts, focusing on the CRS program and benefits for referral.

## **F. HEALTH SYSTEMS CAPACITY INDICATORS**

The most recent estimates for health systems capacity indicators (HSCs) available to the writer on June 8, 2005, are reported in the narrative. Currently unavailable estimates for 2004 will be reported on forms as they become available, but not discussed in this narrative. (In this document, comparison of estimates over time is based on a multiplicative model unless stated otherwise.)

A discussion of HSCs follows. Several, though not all, of the HSCs are discussed in the State's FY 2004-05 MCH Needs Assessment Report, which is among the references listed in Appendix C. (Appendices are obtainable as described in Section III.A.) In the following discussion, however, HSCs are cross-referenced with the Needs Assessment Report only if that report provides additional information about the HSC or a related indicator.

**Health Systems Capacity Indicator (HSC) #1:** The rate of children hospitalized for asthma (ICD-9 Codes:493.0-493.9), per 10,000 children less than 5 years of age.

All estimates for this indicator pertain to CYs.

The State still does not have a representative, centralized hospital discharge database nor firm plans to develop one. Until FY 2003, FHS attempted to estimate the asthma hospitalization rate among preschool children by contacting certain hospitals to request counts for the numerator, and to roughly estimate the number of 0-4 year-old children in the responding hospitals' coverage area. Securing the participation of key hospitals over time proved unfeasible, however. Moreover, little confidence could be placed in the roughly estimated denominator.

For 2002 and 2003, however, Blue Cross and Blue Shield of Alabama (BCBS) and Medicaid provided numbers for estimating the asthma hospitalization rate in preschool children enrolled in their respective plans. We believe that numbers provided by these 2 organizations collectively represent most Alabama children under 5 years of age. Estimates for 2002 and forward use the total number of discharges for hospitalizations due to asthma among children 0-4 years of age enrolled in either of these 2 plans as the numerator, and the estimated population of 0-4 year-old Alabama children as the denominator. (The reason for using this denominator is discussed later.) Per this method, we estimate the CY 2002 asthma hospitalization rate in Alabama children less than 5 years of age to be 67.3 hospitalizations per 10,000 children aged 0-4 years, and the corresponding rate for CY 2003 to be 90.6 hospitalizations per 10,000 children aged 0-4 years. In spite of the problematic denominator for this estimate, we have more confidence in the estimate for 2002 than in those for previous years. For this reason, we report numbers for 2002 as the best estimates for 2000 and 2001 as well.

This estimate for 2003 (90.6/10,000) is 34.5% above the corresponding estimate (67.3/10,000) for 2002. Having estimates for only 2 years, or even for 3 years as should be the case by July 2005, we cannot confidently describe trends in this indicator. (As previously stated, the numbers listed for 2000-2001 are actually the estimates for 2002.)

The absolute number of reported discharges for inpatient hospitalizations due to asthma for Medicaid enrollees aged 0-4 years increased by about half (51.7%): from 1,488 in 2002 to 2,258 in 2003. The corresponding number of reported discharges for BCBS enrollees aged 0-4 years was relatively stable, declining by 10.2% (from 532 in 2002 to 478 in 2003).

The reason for using a population-based denominator, rather than the total reported number of 0-4 year-old enrollees in BCBS and Medicaid, is that for CYs 2002 and 2003 the total reported number of BCBS and Medicaid enrollees in this age group exceeds the estimated population for this age group. This apparently inflated denominator, coupled with failure to capture hospitalizations among children

who are enrolled in other plans or have no insurance, would markedly underestimate the rate. Population estimates provide a relatively stable denominator, and most children in the State are presumably insured by BCBS or Medicaid. Further, the number of reported 0-4 year-old children enrolled in Medicaid declined by nearly one-third (32.2%): from 296,328 in FY 2002 to 200,997 in FY 2003. Two implications of this decline are: 1) The estimated number of Medicaid enrollees may continue to be unstable, and 2) the observed increase in numbers of Medicaid-funded hospitalizations for asthma in 0-4 year-old children was NOT accompanied by increased enrollment. Taking all the preceding issues into account, we consider the estimated population to be the preferable denominator. Nevertheless, we recognize that the reported estimate is likely to be somewhat lower than the actual hospitalization rate of 0-4 year-old children for asthma, since hospitalizations of children who are uninsured or enrolled in other insurance plans are not counted.

As stated under SPM #10, FHS's Social Work Consultant and SCHIP staff are having discussions regarding case management of children who have asthma and diabetes and who also have high utilization of health care services (emergency room visits, hospitalizations, etc.). The possibility of conducting a pilot, in 1 or more sites, to focus on children with asthma is being considered.

HSC #2: The percent of Medicaid enrollees whose age is less than 1 year during the reporting year who received at least 1 initial periodic screen.

All estimates for this indicator pertain to FYs.

Estimates for this measure have far exceeded 100% throughout the surveillance period, but were quite consistent (ranging from 122%-126%) throughout 2001-2003. We assume, for practical purposes, that 90% or more of Medicaid enrollees under 1 year of age receive at least 1 initial periodic screen. See corresponding note to Form 17 for data-related issues.

HSC #3: The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than 1 year during the reporting year who received at least 1 periodic screen.

Estimates for this measure pertain to FYs.

Through the MCH 2002 Report/2004 Application, due to database limitations, estimates for this measure usually exceeded 100%, sometimes by a great deal. (For instance per the MCH 2002 Report/2004 Application, the estimate reported for 2002 was 182.9%.) In FY 2004 SCHIP, BCBS, and Epi/Data Branch staff consulted extensively regarding potential ways to better estimate the proportion of SCHIP enrollees whose age is less than 1 year during the reporting year who received at least 1 initial or periodic screen. Based on these consultations, the previous computation of "percents" that exceeded 100 was mainly for 2 reasons. First, at the time that those MCH reports/applications were submitted, SCHIP could not report unduplicated counts of individuals, so was instead reporting numbers of screens, which inflated the numerator. Secondly, the current enrollment at the end of a given FY was apparently reported as the denominator, making the denominator spuriously low.

Based on the aforesaid consultations, SCHIP developed another method for estimating the numerator and denominator for this indicator. Using the method described in corresponding notes to Form 17, we estimate that, in FY 2003, 64.6% of SCHIP enrollees under 1 year of age received at least 1 periodic screen before their 1st birthday. In stark contrast to earlier methods, the method used in FY 2004 most likely underestimates the proportion of SCHIP infants who receive age-appropriate screens, perhaps markedly. To elaborate, the denominator is the number of children who were less than 1 year of age at any time during the reporting year and were enrolled in SCHIP at any time during the reporting year; and the numerator is the number of such children who had 1 or more initial or periodic screens WHILE LESS THAN 1 YEAR OF AGE at any time during the reporting year. Consequently, an infant who reached 1 year of age before the end of the FY may not have been due for a screen until on or after his or her 1st birthday--and that screen would not have been counted.

As of FY 2004, SCHIP and BCBS planned to continue seeking feasible methods to better estimate

this indicator. For instance, including children in the numerator who were 1 year of age at some time during the reporting year and were screened in that year after their 1st birthday would probably provide a better estimate. Further, SCHIP and BCBS may consider adapting methods being used for any measures derived from the Health Plan Employer Data and Information Set (HEDIS) that involve similar data management or analytic issues. Accordingly, from FHS's perspective, this is a "developmental" health status indicator, for which our methods are evolving. Nevertheless, since the estimate for FY 2003 is data-based, we consider it to be the preferable estimate for any recent year for which the earlier estimate exceeded 100%. Accordingly, we have replaced previous estimates for 2000-2002 with an estimate approximating that for 2003.

HSC #4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

All estimates for this indicator pertain to CYs.

From 1999 through 2003, per the Kotelchuck Index, the proportion of all live-born infants (without respect to race, plurality, or maternal age) whose mothers received adequate (including adequate plus) prenatal care ranged from 77.6% in 2000 to 79.9% in 2003. Thus, the measure varied little over this period, with the percentage in 2003 (79.9%) being just 1.5% higher than that in 1999 (78.7%). Activities to encourage early and adequate prenatal care are described under NPM #18.

Indicators of prenatal care are extensively discussed in Section 3 of the Needs Assessment Report, under the main heading, "Findings: Pregnant Women, Mothers, and Infants." Within that main heading, prenatal care is discussed under the minor subheadings "Health Care Systems Issues," and "Trends in Risk Markers for Infant Death." In the Needs Assessment Report, findings on prenatal care are stratified according to race, source of payment for delivery, and in some cases, maternal age.

HSC #5: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

The following numbers pertain to live births and are for CY 2003. With respect to birthweight, 12.0% of Medicaid infants versus 8.4 % of non-Medicaid infants weighed less than 2,500 grams. Infant mortality rates for Medicaid and non-Medicaid infants, respectively, were 10.6 and 7.0 deaths per 1,000 live births. Mothers of 75.0% of Medicaid infants and 90.4% of non-Medicaid infants had received prenatal care in the 1st trimester; mothers of 74.1% of Medicaid infants and 84.2% of non-Medicaid infants had received adequate or more than adequate prenatal care. The worse experience of Medicaid, versus non-Medicaid, infants is presumably linked to socioeconomic status or factors associated with socioeconomic status. The direction of these differences was the same for all surveillance years, CYs 2000, 2001, and 2003. The "non-Medicaid" subgroup included in HSC #5 includes a typically high risk group: infants of "self paying" mothers, many of whom presumably have neither health insurance nor the means to pay for delivery.

Comparison of outcomes for Medicaid and non-Medicaid subgroups over time is problematic for several reasons. First, the groups may not be demographically stable over time. That is, although Medicaid-eligibility criteria for pregnant women have not changed in recent years, demographic characteristics of women in the Medicaid and non-Medicaid groups could have changed. Clearly, the ethnic composition of the non-Medicaid group, and perhaps the Medicaid group as well, has changed over time. (The increase in Alabama's Hispanic/Latino population is discussed in Section III.A). Further, differences in the prevalence of multiple births can contribute to differences in the prevalence of low birthweight, whether over time or between population subgroups. Finally, as previously stated, the "non-Medicaid" population is a heterogeneous group that includes self-paying mothers, whose infants have typically been at high risk of death. Some of the aforesaid issues are addressed in the Needs Assessment Report. In that report various subgroups, defined respectively by race and source of payment for delivery, are compared with respect to the prevalence of VLBW among singleton infants, certain indicators of prenatal care, and certain other risk markers. (VLBW, rather than low birthweight, was chosen because VLBW is a stronger predictor of infant mortality.) Additionally in the

Needs Assessment Report, various mortality indicators are graphically depicted according to the race and source-of-payment subgroups for 2000-02 combined: risk of infant, neonatal, very early neonatal, and postneonatal death; birthweight-specific risk of infant death; and cause-specific risk of infant death. With respect to source of payment, findings in the Needs Assessment Report are typically shown for infants of Medicaid-enrolled mothers, infants of privately insured mothers and, in some cases, infants of self-paying mothers. Also in that report, depicted trends in the receipt of inadequate prenatal care further stratify the Medicaid group according to ethnicity. These issues are discussed in Section 3 of the MCH Needs Assessment Report, under the main heading "Findings: Pregnant Women, Mothers, and Infants," and under the minor subheadings "Health Care Systems Issues," "Infant Mortality," and "Trends in Risk Markers for Infant Death."

HSC #6: The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (0 to 1), children, and pregnant women.

The upper percent of poverty level parameter for Medicaid eligibility is 133% for infants, children aged 1-5 years, and pregnant women; and 100% for children aged 6-19 years. The SCHIP ALL Kids Program serves eligible infants/children/youth from birth through age 18 years whose household income exceeds the Medicaid criterion for their age group but does not exceed 200% of poverty. These criteria have not changed for several years. Alabama's SCHIP covers pregnant females only if they are less than 19 years of age and eligible for ALL Kids, with household incomes exceeding the Medicaid criterion but not exceeding 200% of poverty.

As discussed in Section III.A and under NPM #18, FHS staff and Alabama SCHIP staff are collaborating regarding the feasibility of expanding SCHIP coverage to include the unborn child. That is, plans are being considered to cover pregnant women whose household income does not exceed 133% of the FPL and who are not eligible for coverage by another entity. Consequently, such expansion would enable provision of insurance coverage for prenatal care, delivery, and postpartum services for women whose household income does not exceed 133% of FPL if they are not eligible for coverage by Medicaid or another insurance program.

HSC# 7: The percent of EPSDT-eligible children aged 6 through 9 years who have received any dental services during the year.

The percent of EPSDT-enrolled children aged 6 through 9 years who received a dental service increased by 47% over a 5-year period: from 33.8% in FY 1999, to 49.8% in FY 2004. The corresponding average annual increase was 8.0% per year, based on a multiplicative model. Issues pertaining to oral health are discussed under NPM #9 and SPMS #12 and #15.

HSC #8: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs Program.

Currently at 16.2%, this indicator has shown a steady declining trend over the past several years. There has been a decrease in the number of CRS enrollees less than 16 years old who were SSI beneficiaries (4,352 in FY 2002, 4,327 in FY 2003, and 3,824 in FY 2004). However, the number of State SSI beneficiaries less than 16 years old has steadily increased from 22,670 in FY 2002 to 23,635 in FY 2003, and has reached 23,677 in FY 2004. This denominator value represents roughly a 4% increase between FY 2002 and FY 2004. This consistently increasing denominator combined with a decrease in CRS enrollees with SSI benefits results in the decrease noted for this indicator. The agency relies on the provision of informational materials and annual inservice visits to local Social Security Administration (SSA) offices to encourage referrals of SSI recipients to the CRS Program. Of those 13,829 clients who are enrolled in the CRS clinical medical program, 36% are SSI recipients under 16 years of age.

HSC #9A: The ability of states to assure that the Maternal and Child Health Program and Title V agency have access to policy and program relevant information and data.



Some issues pertaining to HSC #9A are described in the FY 2005 State SSDI Summary Progress Report, discussed in Section IV.F and located in Appendix E, which is obtainable as described in Section III.A. Each criterion listed for HSC #9A is discussed below.

1) Annual linkage of infant birth and infant death certificates (score = 3)--FHS can routinely obtain data (both per hard copy reports and direct access to electronic databases) from linked birth and infant death files.

2) Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files (score = 1)--Such linkage is not occurring. Under the SSDI Project, in FY 2006 FHS will explore the feasibility of performing such a linkage.

3) Annual linkage of birth certificates and WIC eligibility files (score = 3)--As of early FY 2003, FHS did not have the capacity to perform this linkage. However, through work done as part of the SSDI Project, FHS can now link live birth records with WIC prenatal registration records and has direct access to the linked database. In FY 2004 the SSDI Coordinator presented key findings from preliminary analysis of the initially, though incompletely, linked live birth records/WIC prenatal registration records database to the Director of the WIC Division. The WIC Division Director had a keen interest in the findings and suggested an approach that might achieve a higher proportion of valid links. Based on her advice and other identified measures, the SSDI Coordinator refined the computer program for the linkage and has electronically linked about 85% of FY 2001 WIC prenatal registration records to CY 2000-2001 live birth records. The SSDI Coordinator and WIC staff will further consult regarding the characteristics of WIC prenatal registration records that have not been linked. Selected findings from the linked files are reported in the FY 2004-05 MCH Needs Assessment (reference listed in Appendix C).

4) Annual linkage of birth certificates and newborn screening files (score = 2)--In FY 2003 the SSDI Coordinator electronically linked CY 2000 occurrent live birth records to newborn screening billing records. Using a 2-stage computer program, supplemented by visual inspection of random samples of linked pairs, she roughly estimated that 96.7% of live births could be correctly linked to newborn screening billing records. Thus, FHS can periodically link birth records and newborn screening billing records if such linkage is deemed of high priority. However, FHS does not routinely perform such linkage for several reasons, 1 of which pertains to increased capacity to monitor in a more timely manner whether infants are being screened. With respect to more timely monitoring, concern over possible reasons for the apparently non-linkable records led to development, in June 2004, of the Hospital Newborn Screening Report. This report shows, by hospital, the number of newborns and the number of these newborns who receive initial screens before discharge. Based on these reports, if a hospital did not seem to be screening all their newborns, Newborn Screening Program staff could follow up on individual infants in the hospital. Findings from the report's database (June 2004 through circa March 2005) indicate that more than 99% of Alabama newborns were screened before hospital discharge. In light of these increased capabilities, the need for annual electronic linkage of live birth records to newborn screening billing records has diminished. Specifically, FHS considers more timely ascertainment of whether all infants recently born in hospitals have been screened, which the Newborn Screening Program can now provide, to be more important than routine electronic linkages that do not identify recently delivered infants who may not have been screened.

Other reasons for reassessing the feasibility of annual electronic linkage of live birth records to newborn screening records include: 1) the loss of analytic FTEs in the Epi/Data Branch (discussed in Section III.B), and 2) the Branch's lack of access to the Neometrics, Inc. Case Management System (CMS) database, which is preferable to billing records. Though such access might be granted in the future, other priorities, as well as the diminished FTEs, may keep the Epi/Data Branch from pursuing such access and/or developing computer programs to annually link live birth records with the database. The initial linkage of live birth records to newborn screening billing records has accomplished its main purposes: 1) estimation of the proportion of live birth records that could not be linked to newborn screening billing records; 2) description of certain characteristics of infants whose records could not be linked; and 3) action by key Bureau staff to increase the Bureau's capacity to

monitor in a more timely manner whether infants are being screened. The Epi/Data Branch will consider performing periodic (for instance, every 3 years) linkage of live birth records to the Neometrics, Inc. CMS database if 1) analysis of the linked database would be deemed to have program or policy implications for the Newborn Screening Program, and 2) the branch is granted access to the database.

5) Hospital discharge survey for at least 90% of in-State discharges (score = 1)--The State has neither a centralized, representative hospital discharge database nor, to our knowledge, plans to develop one in the near future. As stated in Section IV.F, FHS considers it highly unlikely that a statewide hospital discharge database will be developed in the near future. This view is based on previous experience and consultations, as well as the lack of a statewide, coordinated infrastructure for a centralized, statewide hospital discharge database.

6) Annual birth defects surveillance system (score = 2)--FHS can sometimes obtain limited reports from a regional (in South Alabama) birth defects surveillance system, but has no access to that system's electronic database. As also stated in Section IV.F, FHS considers it highly unlikely that a statewide birth defects surveillance system will be developed in the near future.

7) Survey of recent mothers at least every 2 years (like PRAMS) (score =3)--FHS has the ability to routinely obtain data from the Pregnancy Risk Assessment and Monitoring System (PRAMS), which is administratively located in CHS. However, other reporting responsibilities have kept the Epi/Data Branch from mastering the PRAMS database layout and the statistical techniques necessary to analyze a database with its complex sampling design. CHS staff produce an annual publication of findings from Alabama PRAMS, however, and typically respond promptly to requests for particular analyses that they do not routinely perform.

HSC #9B: The ability of states to determine the percent of adolescents in grades 9 through 12 who report using tobacco products in the past month.

The 2 criteria for this indicator are discussed below.

1) Youth Risk Behavior Survey (YRBS) (score = 3)--FHS can now query CDC's on-line YRBS database, for both national and State-specific findings, via a CDC web page. Use of this database was an important part of the FY 2004-05 MCH Needs Assessment, and selected findings are discussed in the report of this assessment (reference listed in Appendix C, obtainable as described in Section III.A).

2) Alabama Youth Tobacco Survey (score = 3)--HPCD continues to conduct the Alabama Youth Tobacco Survey in years that the YRBS is not conducted and shares findings with the Bureau upon request. Because CDC's on-line YRBS database can be queried and HPCD shares findings with us, FHS does not consider it necessary to request direct access to either the YRBS database or the HPCD database--especially in light of competing analytic tasks. Certain findings concerning tobacco consumption by youth are discussed in the aforesaid needs assessment report.

HSC #9C: The ability of states to determine the percent of children who are obese or overweight.

The 3 criteria for this measure are discussed below.

1) YRBS (score = 3). Access to YRBS is discussed under NSC #9B. YRBS indicators regarding overweight/obesity and dietary habits were reviewed by the Epi/Data Branch during the FY 2004-05 MCH Needs Assessment.

2) Pediatric Nutrition Surveillance System (PedNSS) (score = 3, up from 1 in FY 2003)--Public Health of Alabama County Operations Network (PHALCON ) collects data on nutritional indicators that are included in CDC's Pediatric Nutrition Surveillance System, PedNSS. After not having submitted data since 1999, ADPH began submitting data to PedNSS in FY 2004. (The non-submission of data to

PedNSS had been due to programming issues and the transition from ADPH's previous data management system to PHALCON.) ADPH's Computer Systems Center and WIC jointly manage and access the WIC database.

3) WIC Program Data (score = 3)--WIC's FYs 2005-06 Nutrition Education Plan for all ADPH WIC clinics focuses on childhood obesity. WIC will periodically compute the number and percentage of WIC-enrolled children who were initially certified or were recertified for enrollment in WIC because of being, respectively, overweight or at risk of being overweight. CDC's criteria, which are based on body mass index percentiles, are used to identify children who are respectively overweight (95th percentile or above) or at risk of being so (85th through 94th percentiles).

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

Determination of the State's priorities, performance measures, and program activities occurs in the context of the Government Performance and Results Act (GPRA, Public Law 103-62). Figure 3 of the guidance for the MCH Services Block Grant reports/applications (reference #2, Appendix C) depicts the Title V Block Grant Performance Measurement System. This system is to begin with needs assessment and identification of priorities and is to culminate in improved outcomes for the Title V population. As shown in Figure 2 of the aforesaid guidance, assessing needs is part of a circular process that includes: assessing needs, examining capacity, selecting priorities, setting targets, identifying activities, allocating resources, and monitoring progress. Each component of this process receives input from a preceding component and feeds into the next component. As also shown in Figure 2 of the guidance, monitoring progress addresses the question of whether an outcome has improved, and the answer to this question feeds into the "identifying activities" component.

When designing, allocating resources to, and implementing programs, key ADPH and CRS staff consider the priority MCH needs identified through the most recent MCH needs assessment. ADPH or CRS supports or directly administers programs to directly address 9 of the 10 priority MCH needs (discussed in Section IV.B) identified through the FY 2000 MCH needs assessment. Neither ADPH nor CRS administers a program mainly designed to address the remaining priority need concerning homicide. ADPH staff have, however, monitored homicide deaths in youth and have ascertained that at least 2 external organizations specifically address violence in youth. Accordingly, the Department's current role regarding this priority need concerns the core public health function of assessment. Section IV.B describes the relationship of the priority needs, the National and State performance measures, and the capacity and resource capability of the State's Title V program.

Accountability for MCH Services Block Grant funds is determined in 3 ways: 1) measuring progress toward achievement of each performance measure; 2) having budgeted and expended dollars spread over all 4 of the service levels shown in the MCH Pyramid, which are direct health care, enabling services, population-based services, and infrastructure-building services; and 3) having a positive impact on outcome measures. Sections IV.C and IV.D pertain to performance measures, Section V to dollars, and Form 12 to outcome measures.

The State Title V Program's role in actions to address each performance measure varies, but falls within 1 or more of the 3 core public health functions of assessment, policy development, and assurance. The State Title V Program's role concerning a given performance measure may, therefore, pertain to 1 or more of the 10 essential public health services, especially to: 1) monitoring health status; 2) informing and educating people about health issues; 3) mobilizing community partnerships to identify and solve health problems; 4) developing policies and plans that support individual and community health efforts; 5) linking people to needed personal health services and assuring the provision of health care when otherwise unavailable; 6) assuring a competent public health work force; and 7) evaluating accessibility of personal and population-based health services. Accordingly, in FY 2003 the Bureau's Executive Committee and the Director of the Epi/Data Branch reviewed the 10 essential public health services, using the Capacity Assessment for State Title V (Cast-5) model (reference #3, Appendix C). The Cast-5 process was interrupted in FY 2004 due to then-urgent fiscal concerns, but some of the concerns identified during that process (such as non-competitive salaries for epidemiologists, discussed under SPM #7) have since been addressed. In early FY 2005 FHS focused on implementing and reporting the FY 2004-05 MCH needs assessment.

Services provided by the State Title V Program are intended to promote health and well-being, as well as to collectively achieve the long-term goal of having a positive effect on the 6 National Outcome Measures in this report/application. Effects of MCH programs are often incremental, rather than dramatic. Further, outcome measures and some "performance measures" (such as very low birthweight, or VLBW) are often influenced by forces beyond the control of the Title V Program. Indeed, various studies have found that programs initiated to prevent preterm delivery and low birth weight—including social support of pregnant women, early prenatal care, and education to increase

awareness of signs of preterm labor--have been largely unsuccessful (reference #4, Appendix C). VLBW, of which prematurity is the major component, is further discussed in Section IV.C.

Sections IV.C and IV.D respectively discuss the 18 National Performance Measures and the 8 State Performance Measures. Performance measures are discussed in numerical order, with a focus on MCH populations served and activities by level of the MCH Pyramid. The following are described for each performance measure: key activities in FY 2004; key activities initiated in early FY 2005; and plans for FY 2006. Where indicated and permitted by space constraints, key activities prior to FY 2004 are reported as a context for FYs 2004-2006. Specific activities are described and categorized by the 4 MCH Pyramid service levels.

The State's MCH applications/reports for previous years have typically included in, or attached to, each performance measure's narrative a discussion of the status and trends for that measure. Such discussion is not provided in this report/application: partly because the report of the FY 2004-05 MCH needs assessment is a competing priority, and partly because the Title V reporting system now shows recent values for each performance measure in close proximity to discussion of that measure.

## **B. STATE PRIORITIES**

### **IDENTIFICATION OF PRIORITY NEEDS VIA FY 2000 MCH NEEDS ASSESSMENT PROCESS**

Through the FY 2000 MCH needs assessment initially reported in July 2000, ADPH and CRS respectively identified 7 and 3 priority MCH needs. A review of the needs assessment process follows and is itself followed by a discussion of each identified priority need, including pertinent needs assessment findings. (The specific year[s] to which cited findings pertain is not always mentioned and varies according to the data source. The most recent pertinent data sources available during the FY 2000 MCH needs assessment were used, and the years for which data were available varied by source. Findings, including the years to which they pertain, are detailed in the report of that needs assessment (listed in Appendix C).

ADPH gathered information mainly through community forums and focus groups, vital statistics, 3 mailed surveys (primary care medical practices, non-medical MCH organizations, and dentists), and a telephone survey of households with children. FHS organized the MCH Needs Assessment Advisory Committee, which was convened on 3 occasions, to provide input into the needs assessment process and selection of priority needs. During the final meeting of this committee, available findings from the needs assessment were presented. The Bureau Director then presented 12 potential priority needs that had been identified by FHS's Needs Assessment Coordinator, based on findings from the needs assessment and in consultation with the Bureau Management Team. Attendees at this meeting were asked to individually (anonymously) rate the needs and then to join breakout groups. Each group was asked to collectively identify and rank the top 5 priority MCH needs and present their selections. Subsequently, based on review of the Advisory Committee's individual ratings and group rankings, FHS's Needs Assessment Coordinator recommended 7 priority MCH needs, which were approved by the Bureau's Executive Committee.

CRS convened the CRS Needs Assessment Advisory Committee on 4 occasions, and pursued 3 methodologies in gathering qualitative and quantitative data: 8 family forums, county-level surveys of public providers coordinating care for CSHCN, and development of a county profile for CSHCN. Findings from these studies were presented at the final meeting of the CRS Needs Assessment Advisory Committee, and input from participants on suggested priority needs was obtained. Subsequently, the CRS Administrative Team members and CRS family representatives jointly selected 7 areas as priorities for improvement. A core planning team within the CRS State Office then selected the 3 priority MCH needs pertaining to CSHCN that CRS has the mission to address.

With 2 exceptions, priority needs are organized below by level of the MCH Pyramid where they were first mentioned in previous MCH reports/applications. Most needs, however, pertain to more than 1 level. Terminology used in subsequent sections to refer to each need is shown parenthetically. Key

findings on which the selection of priority MCH needs were based are summarized. See Form 14 for a simple list of the needs. The priority needs listed here and on Form 14 are those identified from the FY 2000 MCH Needs Assessment and were in effect throughout the reporting year, FY 2004. (The FY 2004-05 needs assessment process and corresponding priority needs are described in the report of that assessment [cited in Appendix C]).

## DIRECT SERVICES

Promote health education and outreach regarding high priority topics, per qualitative and quantitative data (promote education/outreach): This need also pertains to the population-based and infrastructure levels. Needs assessment findings supporting health education and outreach as a priority need included those from the Medical Practices Survey suggesting that limited health education was being provided to patients, that improvement was needed with respect to tracking of immunizations and provision of counseling about appropriate sleep position for infants, and that the proportion of adolescents who used tobacco was unacceptably high. Many performance measures pertain to this need: NPMs #1 (newborn metabolic screening), #7 (immunizations), #8 (teen birth rate), #10 (motor vehicle crash death rate for children), #11 (breastfeeding), #12 (screening newborns for hearing impairment), #13 (uninsured children), #14 (Medicaid-paid service for eligible children), #16 (suicide deaths among youth); and SPMs #1 (folic acid intake), #2 (development and analysis of key MCH databases), #3 (assuring access to case management), #4 (children receiving case management), and #5 (promoting use of dental care).

## ENABLING SERVICES

Assure access to dental care, especially for low-income children (assure dental care): This need also pertains to the population-based and infrastructure-building levels. Multiple findings from the needs assessment supported the designation of this issue as a priority need. Several of these findings suggested that utilization of and/or access to dental care was a problem, especially for Medicaid-enrolled children. For example, per the Telephone Survey, Medicaid-enrolled children were more likely to experience delay in getting dental care than were children with private insurance. Per the Dental Survey, only 11% of dentists said that they accepted new Medicaid clients. Moreover, only about 1/3 of EPSDT-eligible children aged 6-9 years were estimated to have received dental services in FY 1999. Additionally, several findings suggested that access to dental care was a problem, without reference to insurance status. For example, per the Telephone Survey, dental care was delayed more often for children than other types of care were. Also per the Telephone Survey, about 1/4 of the referent children had not been checked by a dentist within 1 year--with lower income (household income under \$25,000 per year), African American, and uninsured children being less likely than their respective referent groups to have had a dental checkup. Moreover, per the Medical Practices Survey, dental care was among the types of services for which access was reported to be most problematic. NPM #9 (protective dental sealants), SPM #3 (assuring access to case management), SPM #4 (children enrolled in case management), SPM #5 (promoting use of dental care), and SPM #8 (dentists serving Medicaid-enrolled children) pertain to this need.

## POPULATION-BASED SERVICES

Improve health status of CSHCN through increased access to primary, specialty, and subspecialty care (improve health status of CSHCN): This need pertains to all 4 levels of service, but especially to population-based, since it concerns outreach/public education. Needs assessment findings through the family forums and county provider surveys indicated that inadequate access to care for CSHCN continued in the State, as evidenced by the reported lack of transportation, limited knowledge of resources, inadequate financing, and limited availability of providers. NPM #3 (coordinated care for CSHCN), NPM #4 (health insurance for CSHCN), NPM #5 (easily used community-based service system for CSHCN), and SPM #7 (public awareness of Title V CSHCN programs) pertain to this need. This need has been re-designated as a population-based service because of its relationship to outreach and public education.

Further reduce the adolescent pregnancy rate (reduce adolescent pregnancy): Needs assessment findings supporting this issue as a priority need included the following. First, teen pregnancy was ranked 2nd by adolescents (behind early sexual activity) when asked what the greatest problems teens face today were, and early sexual activity was ranked by participants in Women's Health Focus Groups as being of greatest concern. Second, though the live birth rate for adolescents aged 15-17 years had notably declined, further improvement was needed, and repeat adolescent pregnancies continued to occur. NPM #8 (teen birth rate) and SPM #6 (programs to prevent adolescent pregnancy) pertain to this need.

## INFRASTRUCTURE-BUILDING SERVICES

Reduce infant mortality in the African American population (reduce African American infant mortality): The racial gap in infant mortality had long been identified as a major concern in Alabama, as well as the Nation. In Alabama, African American infants had been about twice as likely to die before their 1st birthday as were white infants. Normal birth weight African American infants were 1.3 times more likely to die than their white counterparts, so the well known higher prevalence of low birth weight among African American versus white infants did not entirely explain the racial infant mortality gap. NPM #17 (delivery of VLBW infants at appropriate facilities) pertains to this need.

Reduce the prevalence of VLBW in the African American population (African American VLBW): VLBW infants were much more likely to die than normal birth weight infants, and African American mothers were more than twice as likely to have VLBW babies as white mothers or mothers of other races. During the study period, the proportion of singleton infants who were VLBW had stayed about the same for white infants but increased markedly for African American infants. Although the racial disparity in VLBW did not entirely explain the racial infant mortality gap, it accounted for much of the gap, and notably reducing the prevalence of VLBW in African American babies would notably reduce their infant mortality rate. NPM #15 (VLBW) pertains to this need.

Assure access to prenatal care, especially for low-income, minority, and immigrant populations (assure prenatal care): Several of the findings supporting this issue as a priority MCH need pertain to Alabama's Hispanic/Latino immigrants. The number of live births to Hispanic/Latino Alabama residents had increased more than 4-fold in the study period and, in 1998, 10% or more of residential live births in 4 counties were to Hispanic/Latino mothers. With respect to source of payment for birth, deliveries of nearly 1/3 of Hispanic/Latino live births in 1999 were uncompensated. Moreover, the rate of improvement in the percentage of live births to pregnant women who received early prenatal care had slowed in the late 1990s, and this slower improvement was not largely explained by the increase in numbers of uninsured Hispanic/Latino women. Further, racial and economic disparities in the proportion of women receiving inadequate or no prenatal care existed. Bureau staff believed that managed care for Medicaid-eligible pregnant women had improved access to private medical providers throughout the State, but that uninsured women had difficulty accessing care. NPM #18 (early prenatal care) pertains to this need.

Increase family participation in CSHCN policy making and in family-to-family support services (increase family participation). Through family forums, families of CSHCN expressed the lack of necessary family supports in the State. Inadequate access to respite care, mental health counseling, and parent support/advocacy networks were specifically mentioned by families. These inadequacies justify the continuing emphasis on listening to the voices of families in CSHCN policy making and in the development of family-to-family support services. NPM #2 (families partnering in decision making) pertains to this need.

Improve the capacity of CSHCN to be fully integrated into their communities to live, learn, work, and play (integrate CSHCN): Through public forums, families reported their frustration with the inadequate integration of their children with special needs into communities. They noted inadequacies in educational and health-related services from public education, accessibility of facilities, community recreational opportunities, and transitions from school to work and independence. NPM #6 (transition of youth with special health care needs to adult life) and SPM #16 (referral of CSHCN to AVRIS, using

the previous numbering system for SPMs) pertain to this need. SPM #16 is being discontinued, however, for 2 reasons: 1) Related activities are now addressed under NPM #6, and 2) our experience has shown that an individualized transition plan is more effective than a rigid procedure of referral to AVRS at 16 years of age.

Reduce deaths of children and youth due to homicides (reduce homicides). Although the homicide/legal intervention death rate for 15-19 year-old African American males (as estimated by the rate for African Americans and other-than-white races) had declined sharply during the study period, a wide racial disparity persisted. This disparity supported the priority need to reduce deaths of children and youth due to homicides, particularly for African American male adolescents. State Outcome Measure #2 (homicide death rate for African American male adolescents) pertains to this need.

#### RELATIONSHIP OF PRIORITY NEEDS, PERFORMANCE MEASURES, AND CAPACITY/RESOURCE CAPABILITY OF THE STATE TITLE V PROGRAM

The preceding discussion lists the most relevant performance measures (and, in 1 case, outcome measure) for each priority need. FHS's and CRS's plans are based on their overall missions, recent developments, findings from studies conducted as part of 5-year MCH needs assessments and ongoing needs assessment, and input from each agency's needs assessment advisory groups. Further, FHS's plans are based on input from SPAC.

Fiscal issues facing ADPH and CRS in the past have been described in previous MCH reports/applications, and issues affecting current capacity are detailed in Sections III.B and III.D. To briefly recap, projected shortfalls in State revenue for FY 2004 caused ADPH to aggressively cut or redirect expenditures, which affected certain FHS programs or contracts. Some of the expenditures were redirected to sustain SPP and the State Dental Program, though not at previous levels. Through careful use and, when necessary, redirection of funds, ADPH has maintained, and in some ways enhanced, its capacity to serve Title V populations. As discussed in Section III. A, FHS and some CHDs have shifted their focus from direct services provided in the CHD to enabling services and community-based services. CRS has implemented significant budget reductions resulting in cuts to purchased services for CYSHCN, as well as policy changes affecting programs and contractual agreements. The CRS staff has focused on informing families and assisting them in locating alternative resources to fill any unmet needs. In addition to providing education to lawmakers related to the unique needs of CYSHCN, agency leaders and families have concentrated on public awareness of the potential impact of budget cuts in the hopes of securing additional funding and avoiding further reductions to critical services for families.

Activities discussed in Sections IV.C and IV.D address specific performance measures and occur in the context of FHS's and CRS's respective missions and strategies.

### C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0



Numerator	77	70	67	78	59
Denominator	77	70	67	78	59
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100

### Notes - 2002

These results are for calendar year 2002.

The State does not have a policy regarding metabolic or hemoglobinopathy screening for older children. However, the Alabama Department of Public Health contracts with seven community-based sickle cell organizations in the State to provide patient education, counseling, training, and support. In addition, there are two comprehensive sickle cell centers at the University of Alabama at Birmingham and the University of South Alabama in Mobile, who provide sickle cell testing, diagnosis, counseling, and treatment for pediatric and adult clients.

For the screening test Congenital Adrenal Hyperplasia (CAH), the number of confirmed cases is equal to the number of presumptive positive screenings. Per the program coordinator, the results reported are correct because "the screening methodology is highly sensitive and few false positives are identified for CAH. Also, additional cases may be identified from the State's routine second screening." Thus, the protocols established for identification in Alabama ensure that the results are reported. Of the four babies diagnosed in 2002 with CAH, two were born in 2001 and two were born in 2002.

In Alabama, two individuals were diagnosed with hyperphenylalaninemia. These patients do not have classical PKU, but they will require follow-up treatment that will consist of a protein-restricted diet, as well as monitoring of blood lead levels. This follow-up treatment will be provided at the Sparks Clinic in Birmingham, Alabama.

Eleven individuals screened for Galactosemia were diagnosed as Duarte carriers, and thus do not have Classical Galactosemia. These patients will be followed-up, with a treatment that consists of a lactose-restricted diet, for a period of one year at the Sparks Clinic.

### Notes - 2003

These results are for calendar year 2003.

The State does not have a policy regarding metabolic or hemoglobinopathy screening for older children. Effective 12/3/2003, the Bureau of Clinical Laboratories discontinued adult hemoglobin testing. However, the Alabama Department of Public Health contracts with 7 community-based sickle cell organizations in the State to provide patient education, counseling, training, and support. In addition, there are 2 comprehensive sickle cell centers at the University of Alabama at Birmingham and the University of South Alabama in Mobile, who provide sickle cell testing, diagnosis, counseling, and treatment for pediatric and adult clients.

For the screening test Congenital Adrenal Hyperplasia (CAH), the number of confirmed cases is equal to the number of presumptive positive screenings. Per the program coordinator, the results reported are correct because "the screening methodology is highly sensitive and few false positives are identified for CAH. Also, additional cases may be identified from the State's routine second screening." Thus, the protocols established for identification in Alabama ensure that the results are reported.

In Alabama, 1 individual was diagnosed with hyperphenylalaninemia. This patient does not have classical PKU, but will require follow-up treatment that will consist of a protein-restricted diet, as well as monitoring of blood lead levels. This follow-up treatment will be provided at the Sparks Clinic in Birmingham, Alabama.

Six individuals screened for Galactosemia were diagnosed as Duarte carriers, and thus do not have Classical Galactosemia. These patients will be followed-up, with a treatment that consists of a lactose-restricted diet, for a period of one year at the Sparks Clinic.

Maple Syrup Urine Disease (MSUD)- 1 new diagnosis. Currently, patients in Alabama are not screened for this condition, but will be with the implementation of Tandem Mass Spectrometry (MS/MS).

#### **Notes - 2004**

These results are for calendar year 2004.

The State still does not have a policy regarding metabolic or hemoglobinopathy screening for older children. Please see year 2002 or 2003 notes above for additional comments.

For the screening tests Phenylketonuria (Classical), Sickle Cell Disease, and Congenital Adrenal Hyperplasia (CAH), the number of confirmed cases is equal to the number of presumptive positive screenings.

Please see year 2002 or 2003 notes above for additional comments.

In Alabama, two individuals were diagnosed with hyperphenylalaninemia. Please see year 2002 or 2003 notes above for additional comments.

Five individuals screened for Galactosemia were diagnosed as Duarte carriers, and thus do not have Classical Galactosemia. Alabama no longer follows up DG variants.

Objectives have remained at 100% for several years, and will remain there unless the status of this indicator changes.

#### **a. Last Year's Accomplishments**

##### **Crosscutting:**

Building the infrastructure for the tandem mass expansion of the newborn screening program and educating providers and consumers about the new tests were the focal tasks for FY 2004.

##### **Direct:**

For FY 2004 the following number of infants were identified as having hemoglobinopathies or the specified metabolic disorders: hemoglobinopathies, 35; galactosemia, 1; PKU, 3; congenital hypothyroidism, 14; congenital adrenal hyperplasia, 6; biotinidase deficiency (partial), 2; and medium chain acyl-CoA dehydrogenase deficiency (MCAD), 1.

##### **Population-based:**

In April 2004 the Newborn Screening Program began informing healthcare providers and the public about the expansion of the Program. Over 1,500 letters were mailed statewide to active pediatricians, pediatric office nurses, and nurse managers in delivering hospitals. News articles were submitted to the Alabama Medical Association, Alabama Chapter of the American Academy of Pediatrics (AAP, Alabama Chapter), Alabama Hospital Association, AMOD, and ADRS. In May 2004 educational materials were developed for disorders detected by tandem mass spectrometry. The Newborn Screening website was revised to include disorder fact sheets, the State Law and the Rules and Regulations, a disorder summary table, and Alabama Voice Response System (AVRS) information. The Alabama Voice Response System provides authorized health care providers prompt access to screening results.

Infrastructure-building:  
Operation of AVRS continued.

A Hospital Newborn Screening Report was created in June 2004 that shows, by hospital, the actual number and percentage of newborns who received an initial screening prior to hospital discharge. Data extracted from the report, which is produced monthly, indicates that more than 99% of Alabama's newborns received their initial screening prior to hospital discharge.

In September 2004 a contract was signed between FHS and UAB to provide funds for a registered nurse to assist Dr. Rutledge, the UAB metabolic specialist who performs confirmatory testing on newborns who have screened positive for a metabolic disorder. As well, Dr. Rutledge provides long-term medical management for newborns identified as having metabolic disorders, and provides consultation to their families. Further, Dr. Rutledge serves as a resource for provision of educational counseling and materials to parents, practitioners, and consumers. As well, Newborn Screening Program staff continued to collaborate with USA to assure that infants whose screening tests were positive received confirmatory diagnosis and treatment. Such infants included those referred to USA, as well as those born at that facility.

Reporting of the first panel of expanded screening tests was postponed due to Hurricane Ivan, which struck Alabama at the time that instrumentation for expanded screening was being installed, and thereby delayed full installation.

FHS continued educating providers, parents, and consumers on newborn screening practices.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide biochemical screening of newborns for mandated conditions.	X	X	X	X
2. Through use of Tandem Mass Spectrometry, incrementally add tests for other disorders to the screening panel.	X	X	X	X
3. Refer infants testing positive, per any of the screening tests performed, for diagnostic follow-up.		X		X
4. Collaborate with metabolic specialists from the University of Alabama at Birmingham and the University of South Alabama, to assure follow-up of newborns testing positive and/or to develop and provide educational materials.		X	X	X
5. Periodically submit information to the National Newborn Screening and Genetics Resource Center, for the purpose of establishing an electronic reporting system for newborn screening data.				X
6. Include information about newborn screening in the Alabama Department of Public Health's curriculum for training care coordinators.				X
7. Annually produce a Hospital Newborn Screening Report that shows, by hospital, the percentage of newborns who were screened before discharge.				X
8. Operate an automated voice response system providing results to authorized health care providers.				X
9.				

## b. Current Activities

### Cross-cutting:

In October 2004 the first panel of analytes was reported. The panel includes analytes that screen for the following disorders: maple syrup urine disease, homocystinuria, tyrosinemia, citrullinemia, MCAD, propionic acidemia, methylmalonic acidemia, and carnitine transport defect.

### Direct:

There are 9 PKU patients receiving medical food/special formula through the Title V program.

### Population-based::

A second round of press releases and provider notification letters were distributed to the same groups as last year.

### Infrastructure-building:

BCL and FHS staff continue to work closely with Dr. Rutledge to establish cut-off values for testing and follow-up protocol/guidelines. In October 2004 FHS requested that specific amino acid products be added to the State Medicaid Formulary. These products became available in December 2004. State-specific disorder information was submitted to the National Newborn Screening and Genetics Resource Center for the purpose of establishing an electronic reporting system for newborn screening data. As of January 2005 AVRS has 2,102 registered providers (down slightly from 2,198 in FY 2003)

A newborn screening update was added to FHS's Care Coordination training agenda in April 2005. Upon request, care coordinators assist with follow-up to assure all infants identified are in a system of care. The first Alabama Newborn Screening Conference for pediatricians, nurses, nutritionists, social workers, and lab staff is scheduled for June 2005 in Montgomery. Conference objectives are to provide health care professionals current information on newborn screening issues in Alabama and to highlight the various components of Alabama's Newborn Screening Program.

ADPH continues to produce the Hospital Newborn Screening Report.

## c. Plan for the Coming Year

### Infrastructure-building:

The Newborn Screening Program will continue to:

- 1) Expand the current newborn screening test panels.
- 2) Develop and refine program protocols and guidelines.
- 3) Work with UAB and USA to assure that infants whose screening tests are positive receive confirmatory diagnosis and treatment.
- 4) Produce the Hospital Newborn Screening Report.
- 5) Operate AVRS.

Further, Newborn Screening Program staff will educate pediatric providers and hospital birthing centers' staff on blood specimen collection and handling procedures and the importance of decreasing the prevalence of unsatisfactory specimens. Additionally, they will develop a Newborn Screening Practitioner Manual.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			66	66	66
Annual Indicator			66.1	66.1	66.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	66.1	66.1	70	72	77

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

## Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

### a. Last Year's Accomplishments

Using data from Summary Tables of the National CSHCN Survey, 2001 (US Dept. of Health and Human Services [DHHS], April 28, 2003), 66.1% of Alabama families with CSHCN (vs. 57.5% nationally) reported partnering in decision-making at all levels and being satisfied with services received. 91.0% reported the physician usually or always made them feel like a partner (vs. 84.3% nationally). 66.2% reported they were very satisfied with services received (vs. 60.1% nationally).

#### Enabling:

CRS continued to employ a State Parent Consultant (SPC) and 12 Local Parent Consultants (LPCs). The State Parent Advisory Committee held 2 meetings. Local Parent Advisory Committees hosted speakers on topics such as Medicaid Waivers, Social Security and SSI, special education laws and rights, and the AL Respite Resource Network. Work continued on the Alabama Council for Developmental Disabilities grant to Family Voices to study barriers to health care for people with disabilities and to develop an advocacy plan in response. A taskforce developing the CRS Family Guide completed a first draft.

#### Population-based:

CRS continued to publish the Parent Connection Newsletter, which is available by mail, in CRS offices and on the ADRS website. It is also sent to national editors for CSHCN newsletters. A listserve was maintained for participants in the Parent to Parent Program, with 334 messages posted in FY 2004.

LPCs presented trainings on family-centered care and disability-related issues at schools, childcare centers, etc. Disability awareness was promoted through community Health Fairs and SAFE Kids Car Seat Checks.

#### Infrastructure-building:

The SPC and a CRS parent serve both as the as Region IV and FV of Alabama State Co-Coordination. CRS continued to support and partner with FV. Grants were developed to provide reimbursement for support for families to participate in 2010 workgroups and to plan, promote, and host 8 family forums as a part of the Needs Assessment process.

As a part of the FV national data collection project, LPCs track types of services reported as lacking by families and the type of information provided by LPCs to families and professionals. In FY2004, information was provided to 6,824 families and 1,822 professionals. Health care financing was the most common topic, typically about public programs including Medicaid, Medicaid Waivers, All-Kids, Title V, and SSI.

LPCs attended State and National trainings. One LPC graduated from Partners in Policymaking

of Alabama. LPCs and families participated on CRS and interagency committees and task forces, as described in Section E. The SPC was involved in trainings, both as presenter and participant. She served on the AMCHP Best Practices Committee and Family Advisory Group; on interagency planning groups such as the Covering Kids Project, Inclusive Childcare Project, AL Arise Health Caucus, Early Intervention Conference Planning Committee; and co-chaired the AEIS Program Planning and Evaluation Committee.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for Children and Youth with Special Health Care Needs (CYSHCN).		X	X	X
2. Facilitate collaboration/partnerships through Children's Rehabilitation Service (CRS) State/local parent advisory committees.		X	X	X
3. Facilitate collaboration/partnerships through training activities.		X	X	X
4. Facilitate collaboration/partnerships through publication of a newsletter.		X	X	X
5. Facilitate collaboration/partnerships through employment of Parent Consultants.		X	X	X
6. Support the growth of Family Voices, financially and philosophically, including utilization of CRS/Family Voices database.		X	X	X
7. Include youth and parents of CYSHCN as co-presenters at all training events.		X	X	X
8. Publish a Family Guide to the CRS Program and develop training for staff and families on its use.		X	X	X
9. Partner with families to include family-centered care in the enhanced Care Coordination Program and insure family participation in development of training process and materials.		X	X	X
10.				

#### b. Current Activities

##### Enabling:

LPCs continue to be supported in CRS district offices. The SPC and the parent of a CRS-enrolled child have been selected to a second 2-year term as the Regional Co-coordinators for Family Voices. In June, 2005 CRS presented the FY 2006 draft State plan for CYSHCN, FY2004-2005 needs assessment findings, and a handout of activities related to the characteristics documenting family participation in CSHCN programs as listed on Form 13 to a meeting of the State Parent Advisory Committee. Following this discussion, the state office administrative staff, including the State Parent Consultant, finalized the scoring of Form 13 utilizing a checklist format modified from a tool developed by the State of Wisconsin in December 2001. The scored checklist is attached to this subsection. The CRS Family Guide Task Force will engage in extensive revisions of the first draft of the guide due to changes within the CRS program. The listserve for participants in the Parent Connection Parent to Parent Program continues, however certain issues related to its host site, Yahoogroups are impacting the number and volume of messages.

##### Infrastructure-building:

Work continues on the Alabama Council for Developmental Disabilities grant to study barriers to health care for people with disabilities and to develop an advocacy plan to address these

barriers. LPCs continue to use the data collection system to provide information on types of services and information requested by families and professionals. The SPC, LPCs and families continue to participate on a variety of CRS and interagency committees, task forces, and all 2010 workgroups, including the Family/Professional Partnership workgroup specifically addressing the 2010 goal of parent satisfaction and partnering in decision-making.

### c. Plan for the Coming Year

#### Enabling:

Family/professional collaboration in program and policy activities will be facilitated through support of families for CRS State/local parent advisory committees, training activities, publication of a newsletter, and employment of at least 1 Parent Consultant in each office. CRS will have youth and parents of CYSHCN as co-presenters at all staff and community trainings. CRS will publish a Family Guide to assist families in understanding the CRS Program and making informed choices regarding services, as well as develop and provide training on utilizing the Family Guide.

#### Infrastructure-building:

During FY 2006, CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 families of CYSHCN will partner in decision-making at all levels and will be satisfied with the services they receive. CRS will support, financially and philosophically, the growth of Family Voices within the State through the provision of leadership, the dissemination of information, and the continued utilization and analysis of data gathered through the CRS/Family Voices database. Additionally, CRS will partner with families to insure that the principles of family-centered care will be incorporated into an enhanced Care Coordination Program and that families will be active participants in the development of the training process and related materials.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective			53	53	53
Annual Indicator			53.9	53.9	53.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	53.9	53.9	60	62	67



## **Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

## **Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

## **Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

### **a. Last Year's Accomplishments**

Using data from Summary Tables of the National CSHCN Survey, 2001 (DHHS, April 28, 2003), 53.9% of CSHCN have a medical home (MH) in Alabama vs. 52.6% nationally. 93.2% of Alabama families reported having a usual source of care vs. 90.5% nationally. Within the CRS Program, 98% of enrollees in FY 2004 reported a usual source of care (a stable figure since FY 2002), representing great improvement from its FY 1996 baseline of 62%. Usual source of care was reported by 95% of youth in survey from the current needs assessment. These youth were not all CRS enrollees so they may not have had CRS staff assistance in linking to primary care providers (PCPs), but the lower figure may suggest difficulties in maintaining a usual source of care as youth age.

### **Enabling:**

CRS staff engaged in ongoing efforts to identify community PCPs willing to accept CYSHCN as patients. Families without MHs were assisted with linkage to appropriate community PCPs. A database of PCPs of CRS enrollees was used in identifying local providers with experience

with CYSHCN to facilitate linkage. The Medicaid web page includes a roster of available PCPs by county. The 55% of CRS enrollees with Medicaid were provided a MH through the Patient 1st Program. Although the original Patient 1st expired in February 2004, the creation of a new federal waiver and new Patient 1st Program focused heavily on the provision of a true MH. CRS works closely with Medicaid providers to receive appropriate referrals to facilitate comprehensive EPSDT services.

**Population-based:**

CRS collaborated with colleagues through the MH 2010 workgroup to bring a MH training session, provided by a mentor physician and family representative, to the winter meeting of the Alabama Chapter of AAP. Information was provided to physicians about MHs through the Alabama AAP Chapter newsletter. One physician newsletter, "MD Connect," was published in August and mailed to State pediatricians and physicians listed as PCPs through Medicaid. MH information was included in the Winter 2003 and Spring 2004 editions of the CRS Parent Connection.

**Infrastructure-building:**

The CRS Medical Advisory Committee, including PCPs and specialists across the State, met twice in FY 2004. Medicaid is in the final stages of developing MH continuing medical educational materials in a CD-ROM (Compact Disc-Read Only Memory) format. This material targets Medicaid PCPs, but will also be available to allied health professionals. CRS contributed to this project and is listed as a resource for CYSHCN. CRS and Family Voices of Alabama have participated in beta testing of the CD-ROM. CRS developed courtesy staff privileges for enrolled PCPs, so that certain physician orders may be recognized for CRS reimbursement. This facilitates better coordination between CRS and the MH and assists in streamlining the system of care for CRS clients. The MH 2010 workgroup has been active through quarterly meetings and ongoing progress towards action steps.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	X
2. Publish at least 1 physician newsletter.			X	
3. Feature medical home concept in newsletters and the CRS Family Guide.		X	X	
4. Distribute information through the State Child Health Insurance Program (SCHIP) about medical home and the CRS Program to families.			X	
5. Provide ongoing educational and agency-related materials to enhance partnerships with primary care physicians recognized as CRS courtesy staff.			X	X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

**Enabling:**

The newly created federal Medicaid waiver for Patient 1st, a primary care case management

model, gradually went into effect during early FY 2005. The new Patient 1st was developed with a similar structure to the previous program and provides financial incentives for physicians to provide a true medical home (MH) and to perform EPSDT screenings.

**Population-based:**

MH information continues to be shared with CRS courtesy staff physicians through the physician newsletter, "MD Connect." An article related to MH was included in the Spring 2005 edition of the CRS Parent Connection newsletter. CRS continues to collaborate with All-Kids, Alabama's SCHIP, to establish a protocol for including information about MH and the CRS program in a packet of information for families who indicate that they have a child with special health care needs during the application process.

**Infrastructure-building:**

The Medicaid CD-ROM training related to MH is now available and is currently being utilized by primary care providers. CRS continues to facilitate and support a workgroup addressing activities and planning to meet the 2010 objective of MH provision for CYSHCN.

**c. Plan for the Coming Year**

**Enabling:**

CRS staff will continue to meet with new community medical providers to identify primary care physicians willing to accept CYSHCN as patients. Partnerships will be enhanced between CRS and Alabama's primary care physicians who are recognized as CRS courtesy staff physicians through the provision of ongoing educational and agency-related public-policy awareness materials. Families of CYSHCN without medical homes will continue to be assisted at the local level with linkage to appropriate, community-based primary care providers.

**Population-based:**

The exchange of information will be enhanced among CRS, its medical staff, and Alabama primary care physicians, including medical home providers, by the publication of at least 1 physician newsletter. CRS will develop a plan to share client-specific service plan information with medical home physicians.

**Infrastructure-building:**

In FY 2006, CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all CSHCN will receive ongoing comprehensive care through a medical home. CRS will also continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all children will be screened early and continuously for special health care needs.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance			59	59	59

Objective					
Annual Indicator			59.7	59.7	59.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	59.7	59.7	62	65	67

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### a. Last Year's Accomplishments

Using data from the Summary Tables from the National CSHCN Survey, 2001 (DHHS, April 28, 2003), 59.7% of families with CSHCN age 0-18 years in Alabama have adequate private and/or public insurance to pay for the services they need, as compared with 59.6% of families with CSHCN nationally. The percentage of CRS enrollees with 3rd party coverage decreased slightly in FY 2004 to 82.3%, compared to 83.2% in FY 2003. This figure, although above the 81.5% value in FY 2002, continues to lag behind a high of 84.4% in FY 2000. The number of uninsured children in the program in FY 2004 has remained similar to FY 2003 data (2,450 in FY 2004 vs. 2,446 in FY 2003). This represents a 37% decline from the 3,885 uninsured in the first reporting period in FY 1997. FY 2004 activities included the following:

**Direct:**

CRS continued to participate as an ALL Kids Plus provider through Alabama's SCHIP, ALL Kids. The Plus package enhances the ALL Kids benefit package for CYSHCN receiving services through a State-funded entity. Additional services provided included analog and digital hearing aids, audiology services, therapy visits beyond the scope of the usual benefit package, and orthodontia, for which CRS receives additional reimbursement from ALL Kids. For FY 2004, CRS received \$103,802.29 from ALL Kids for basic covered benefits and the enhanced Plus services.

**Enabling:**

Upon enrollment, CRS identifies children with no health insurance who might be eligible for Medicaid, SCHIP, or SSI, and assists with the application process. CRS actively monitored children with ALL Kids to assist them with annual renewal and paid premiums as needed. There were 355 CRS enrollees with ALL Kids coverage in FY 2004, a 12% increase over the 316 in FY 2003. Additionally, CRS paid premiums for 19 clients whose families were unable to afford the premiums for insurance coverage accessible through employment, Consolidated Omnibus Budget Reconciliation Act (COBRA), or the Alabama Health Insurance Plan.

**Infrastructure-building:**

CRS collaborated with ALL Kids to continue ALL Kids Plus, an enhanced service package for CYSHCN, and persists in advocating for the incorporation of additional services for CYSHCN in the basic ALL Kids benefit package as well as for recognition of all 16 AEIS-provided services as Plus-covered services. Training on enhanced services and beneficial programs provided to CYSHCN through CRS was provided to staff from the 16 EIS programs for which the agency is the fiscal agent. CRS completed the planning and development of a pharmacy fee schedule to create a system for better utilization of Title V funds to meet the rising cost of drugs for CYSHCN in the program.

CRS continues to facilitate a workgroup to ensure that by 2010 all families of CYSHCN will have adequate insurance to pay for services they need.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	X
2. Refer 100% of children with no health insurance enrolled with CRS to Supplemental Security Income (SSI), Medicaid, or SCHIP.		X		
3. Continue collaboration with SCHIP and Alabama's Early Intervention System (EIS) to implement a Plus benefit package for EIS services.				X
4. Continue implementation of the CRS work plan for the Health Insurance Portability and Accountability Act, and develop plan to provide				X

training to new and current staff.				
5. Continue collaboration between CRS and the Alabama Department of Public Health for support of expanded services for CYSHCN through the basic SCHIP and SCHIP-Plus packages.				X
6. Identify 100% of CRS clients for whom it is appropriate to pay insurance premiums and provide this service.		X		
7. Implement second phase of new management information system (CHARMS: Children's Health and Resource Management System) to include clinic scheduling and electronic billing for medical services.				X
8. Enhance CHARMS to facilitate third party billing and data collection.				X
9.				
10.				

#### b. Current Activities

##### Direct:

Work on coverage for Early Intervention services through ALL Kids Plus continues, as does advocacy for the inclusion of enhanced coverage for CYSHCN through the basic ALL Kids package.

##### Enabling:

CRS continues to pay health insurance premiums for families who are unable to afford them. In addition, the agency assists with co-payments as needed and provides guidance in completing annual insurance renewal applications upon family request.

##### Infrastructure-building:

Through the State Policy Specialist and Computer Information Systems, CRS provides training and updates for all staff members on HIPAA regulations. Privacy notices are provided to all active clients and families and are posted in all field offices/clinics.

As of October 1, 2004, CRS has initiated a pharmacy fee schedule applicable to drugs purchased for any ADRS client (all divisions). After extensive review, a list of covered prescription/over the counter medications and corresponding fees was developed. Pharmacies throughout the State apply through ADRS to become preferred providers and agree to supply these medications for the negotiated fee. This effort will provide better utilization of Title V funds to meet the rising cost of medications for CYSHCN in the program. Due to budget constraints as discussed in Section III.A, the CRS Diaper Program was suspended as of October 1, 2004. Staff members are closely working with families who previously received this supplement for partial coverage of the cost of diapers to assist in linking them with private providers and community vendors using their third party insurance benefits.

Modifications and updates continue to the CRS information management system to facilitate data collection and enhance 3rd party reimbursements for services provided to CYSHCN. The first phase is anticipated to become active June, 2005.

Support continues for the implementation of activities of the workgroup addressing the 2010 objective of adequate insurance coverage for families of CYSHCN to pay for needed services.

#### c. Plan for the Coming Year

##### Direct:

CRS will continue to be an ALL Kids Plus provider to enhance the expanded ALL Kids benefit package for Alabama's CYSHCN who are eligible for the CRS Program.

**Enabling:**

During FY 2006, 100% of CYSHCN enrolled with CRS who have no health insurance will be referred for SSI, Medicaid, or ALL Kids consideration and will receive assistance with the application. One hundred percent of the CRS clients for whom it would be appropriate for CRS to pay for insurance premiums will be identified and afforded this service.

**Infrastructure-building:**

In FY 2006, CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all families of CYSHCN will have adequate public and/or private insurance to pay for the services they need. CRS will continue to collaborate with ADPH to support expanded services for CYSHCN to be provided through ALL Kids Plus and the basic ALL Kids plan. CRS will continue implementation of its work plan to address client privacy, security, and transaction issues mandated by HIPAA and will provide ongoing training related to HIPAA requirements to current and new staff members. CRS will implement the second phase of its new management information system (CHARMS: Children's Health and Resource Management System) to include clinic scheduling and electronic billing for medical services. CRS will also enhance CHARMS to facilitate third party billing and data collection.

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective			73	73	73
Annual Indicator			73.7	73.7	73.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	73.7	73.7	78	80	85

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the

fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

### **Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

The 2003 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

### **Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

The 2004 indicator is based on the State estimates from SLAITS. It is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### **a. Last Year's Accomplishments**

Using data from Summary Tables of the National CSHCN Survey (2001, DHHS, April 28, 2003), 73.7% of Alabama families with CSHCN reported the community-based service systems are organized so they can use them easily vs. 74.3% of families nationally.

#### **Direct:**

In FY 2004, CRS provided 14,647 clinic visits, responded to 7,352 requests for information and referral, and furnished 76,147 encounters by physicians, dentists, and CRS staff. CRS served 21,831 children, of whom 364 were CYSHCN with TBI. The Alabama Hemophilia Program served more than 300 people with bleeding disorders.

CRS upgraded its facilities to expand access to specialized services. The physical therapy suite was renovated in Birmingham and included donated equipment from a private sector partner. Audiology suites were renovated or added in Opelika, Andalusia, and Dothan. A new office with expanded clinic facilities was built in Andalusia. Remodeling was completed in Dothan Office, and a speech-language pathologist was added to the staff-a new discipline in that district.

Several clinic initiatives were expanded. Birmingham, Mobile, and Jackson began Seating and Positioning Clinics. Opelika and Dothan began Feeding Clinics. The Mobile Neuromotor Clinic began using telemedicine so that the pediatric physiatrist can oversee monitoring and refilling of intrathecal baclofen pumps by the nursing staff in Mobile from his office in Birmingham, allowing access to his expertise without the long drive to Birmingham.



**Population-based:**

CRS staff made presentations at 20 of 21 State SSA offices, increasing awareness of CRS services to facilitate referrals and enhance system usability for families. Local contacts were made with all children newly awarded SSI to offer assistance with service needs.

**Infrastructure-building:**

CRS implemented a new HIPAA-compliant medical billing system, Medisys, throughout its offices. Medisys has enabled CRS to automate its family financial participation billing system and to bill Medicaid and Blue Cross/Blue Shield electronically for services rendered.

CRS continued to provide Title V funding to 3 multidisciplinary specialty service centers in the State. The Medical Genetics Programs at both UAB and the University of South Alabama (USA) provided services to CYSHCN in satellite clinics held at CRS clinics, other community locations, and on-site in Birmingham and Mobile. During FY 2004, USA and UAB held 24 and 10 outreach clinics, serving 198 and 42 families, respectively. Also, the Civitan International Research Center/Sparks Clinics in Birmingham were funded to provide multidisciplinary developmental evaluations for CYSHCN. Sparks Clinics served 1,806 CYSHCN under age 21 years, including 842 new clients, with 99 referred by CRS.

CRS partnered with AEIS to increase access to early intervention services for eligible infants and toddlers through funding to 16 community-based projects throughout the state, serving about 650 children in FY 2004.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	X
2. Serve at least 22,000 CYSHCN through the local CRS offices.	X			
3. Support Alabama's EIS by increasing access to EIS services for eligible individuals.	X	X		X
4. Implement a targeted case management program to create additional funding for eligible children and youth.		X		X
5. Work cooperatively with other agencies to implement a universal newborn hearing screening program.	X	X		X
6. Give a presentation on CRS to the staff in every Social Security Administration office in Alabama.			X	
7. Monitor implementation of an enhanced Care Coordination Program and asses family satisfaction with services.				X
8. Monitor and evaluate statewide initiative to directly dispense hearing aides to children and youth with hearing loss.	X			X
9.				
10.				

**b. Current Activities**

**Direct:**

CRS hired its first occupational therapist in a field office (Mobile), and plans to hire a second in Montgomery by the end of fiscal year. Huntsville began a Neuromotor Clinic, staffed by a local physiatrist. Hearing Assessment Clinics are being implemented to provide assessment for children referred from newborn hearing screening, those identified with risk factors for later

onset hearing loss, and those who failed a previous hearing screen. This follow up will assure that children with hearing loss are identified as soon as possible. The Andalusia Office is developing a Hearing Clinic, a first for that rural area. ADRS hired its first joint VR/CR rehabilitation audiologist to transition youth and young adults with hearing impairment into Vocational Rehabilitation services.

As fully discussed in Section III.A, CRS was forced to reduce its budget for purchased services by 1.5 million dollars. This resulted in service cuts to families including the elimination of certain programs and purchased services, transportation reimbursement reduction, and elimination of funding to the medical genetics programs at UAB and USA. A work group consisting of state office administrators, field supervisors, CRS medical consultants, and family representatives made these difficult decisions.

#### Enabling:

Despite numerous setbacks related to computer software issues, CRS continues the development and implementation of a Medicaid targeted case management program to secure funding for case management services for children and youth with TBI not involved in the agency's Children's Specialty Clinic Program.

#### Infrastructure-building:

Phase I of a new data management system, Children's Health and Resource Management System (CHARMS) is nearing completion. The new system will combine existing data systems into one database and will create an electronic medical record for each client, accessible by each CRS clinic site. The automated service plan and anticipatory guidance educational program in CHARMS will enhance the CRS care coordination program. CHARMS I is scheduled to go live in June, 2005. Work has begun on Phase II, which will feature clinic scheduling and an electronic billing system. CRS has purchased a pharmaceutical billing software program, RX-30, which allows the agency to electronically bill for hemophilia factor and other pharmaceutical products.

CRS continues partnerships to implement Alabama's 2010 Action Plan to address the objectives for CYSHCN. Meeting at least quarterly, 6 workgroups create an action plan for each objective. The consolidated plan is dynamic, evolving as the workgroups complete action steps and envision new activities and strategies. A joint meeting was held in Montgomery on November 22, 2004, highlighting major accomplishments. These included the release of the Medicaid Medical Home instructional CD-ROM, the Pediatric Pulmonary Center's transition CD-ROM, and the implementation of tandem mass spectrometry screening by ADPH.

### c. Plan for the Coming Year

#### Direct:

In FY 2006, at least 22,000 CYSHCN, including SSI recipients, will receive information and referral services, health and rehabilitative services, care coordination services, and enabling services arranged through local CRS offices, including assistance with referrals/applications to other agencies. CRS will also work cooperatively with other public and private agencies in Alabama to ensure access to appropriate diagnostic procedures and intervention services for all children identified with hearing impairments through universal newborn hearing screening.

#### Enabling:

CRS will monitor the implementation of an enhanced care coordination program and assess family satisfaction with services.

#### Population-based:

A CRS representative will present every SSA office in Alabama with information about rehabilitation services, including care coordination, available to CYSHCN through CRS.

**Infrastructure-building:**

During FY 2006, CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 community-based service systems will be organized so that families can use them easily. CRS will support Alabama's Early Intervention System by increasing access to early intervention services for eligible infants and toddlers with special health care needs by the provision of grant funding to community-based projects throughout the State. CRS will implement a targeted case management program to create additional funding for eligible children and youth. Further, CRS will monitor and evaluate the statewide initiative to directly dispense hearing aides to children and youth with hearing loss.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective			6	6	6
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	6	6	10	12	15

**Notes - 2002**

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted. The national average is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

**Notes - 2003**

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2003 indicator is the national average except for Maine which has its State value noted. The national average is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### **Notes - 2004**

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2004 indicator is the national average except for Maine which has its State value noted. The national average is the result of analyses conducted by the staff of the Special Populations Surveys Branch, Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention and provided to the Maternal and Child Health Bureau, Health Resources and Services Administration in the Summary Tables from the National Survey of Children with Special Health Care Needs, 2001 (Department of Health and Human Services, April 28, 2003). All estimates are subject to sampling variability, as well as survey design flaws, respondent classification and reporting errors, and data processing mistakes. The annual performance objectives reflect the fact that the National Survey of Children with Special Health Care Needs will be conducted intermittently and new data may not be available until FY 2007.

#### **a. Last Year's Accomplishments**

Using data from the Summary Tables from the National CSHCN Survey (2001, DHHS, April 28, 2003), 5.8% of youth with special health care needs nationally received services necessary to transition to all aspects of adult life. Alabama rates were deemed unreliable by the National Center for Health Statistics. Activities in FY 2004 included the following:

##### **Direct:**

CRS staff worked individually with youth turning age 21 to ensure linkage to adult health care providers and community systems. Teen Transition Clinic expanded to another site (Mobile) and along with the Birmingham site, these clinics provide a setting for transition planning. A clinic manual was developed and plans are ongoing to expand the clinic to an additional site.

##### **Enabling:**

The Youth Advisory Committee (YAC) continued to advise CRS on policy related to services for youth and to promote development of a service system that facilitates transition to all aspects of adult life. Two conference calls, a meeting, and a retreat were held. Members of YAC include CRS youth who participated in leadership training through the annual Alabama Governor's Youth Leadership Forum (YLF). YLF was held in June 2004, with 9 of the 21 delegates being from CRS.

The CRS Youth Consultant (YC) worked an average of 18 hours per week, advising CRS on issues affecting youth with disabilities and providing leadership to the YAC. She also gives youth input in staff and taskforce meetings and submits articles for the Youth News insert to the CRS Parent Connection. The YC served as Activity Director for this year's YLF. She was appointed to the national board of Kids As Self Advocates (KASA) and participated in conference calls and the annual national meeting. She represented Alabama at the National

Youth Leadership Network Conference in Washington, DC. This youth driven and led organization promotes leadership development and education to ensure that youth with disabilities may attain their maximum, unique, and personal potential.

**Population-based:**

The YC presented during trainings related to occupational therapy and feeding. The ADRS website features a link to Youth Connection Program information. Youth Power workshops on self-determination were held in 2 locations.

**Infrastructure-building:**

The CRS State Youth Coordinator and the VRS State Transition Coordinator established a transition team to identify challenges in the referral and transition process to strengthen the ADRS continuum of services. CRS/VRS offices were visited and staff input was collected to identify needs and barriers. A steering committee was developed, with workgroups targeting identified barriers, and a state plan was created to address these issues.

CRS collaborated on a Developmental Disabilities Council grant through Easter Seal Rehabilitation Services, creating a Personal Care Attendant Services task force, handbook, and CD ROM training on accessing and utilizing this service.

Youth were supported to participate in 2010 workgroup activities.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement Alabama's 2010 Action Plan for CYSHCN.		X	X	
2. Facilitate collaboration/partnerships through support of youth on the CRS Youth Advisory Committee and National Kids As Self Advocates (KASA) Board.		X	X	X
3. Facilitate collaboration/partnerships through training activities, articles in the family newsletter, and employment of a State Youth Consultant.		X	X	X
4. Develop a notebook for youth to organize and retain transition information.		X		
5. Increase Youth Advisory Committee activities to include 2 meetings per year, quarterly conference calls, and information sessions for parents.		X		X
6. Collaborate with Vocational Rehabilitation Services to implement interdepartmental plan to promote transition.		X	X	X
7. Expand Teen Transition Clinic to at least 1 additional site and develop public relations materials.	X		X	X
8. Provide Youth Power workshops in 3 new sites.		X	X	
9. Expand public relations materials regarding Youth Connection activities and build transition resources for CRS program.			X	X
10.				

**b. Current Activities**

**Enabling:**

YAC continues to play an integral role in providing input to CRS on specific issues related to youth with special health care needs. CRS continues to support the Alabama Governor's Youth Leadership Forum, including participation by the State Youth Coordinator and the CRS Youth

Consultant in the Forum and on the steering committee.

Population-based:

Youth willing to be co-presenters for staff and community trainings have been identified. YAC presented a session, "What Does Health Have To Do With Transition?" at the 15th annual Alabama Transition Conference. The session included personal experiences of how health needs affect transition, as well as information on transition topics (adult healthcare, education, employment, recreation, transportation) and the provision of Healthy and Ready to Work handouts as resources for attendees.

Infrastructure-building:

The CRS State Youth Coordinator and the VRS State Transition Coordinator have continued to lead the CRS/VRS Steering Committee and a plan has been approved for the ADRS Continuum in Transition for Youth with Special Health Care Needs (implementation beginning in April). The plan includes transition meetings for CRS youth at age 14 to discuss resources and future plans and the development of a transition plan with referral to VRS as appropriate and desired.

Youth continue to be supported to participate in 2010 workgroups, specifically the one related to transition. This workgroup has divided into 3 subgroups with the following goals: promote independence as it relates to the individual by empowering CYSHCN to achieve life goals, increase employment outcomes for youth with special health care needs, and increase availability and access to all healthcare services needed as children become adults. The workgroup will continue to develop plans around these goals.

Youth input was included in the 5-year needs assessment process through a youth survey and a youth forum. CRS provided public awareness, reimbursement for travel, and a stipend to youth for participating in the forum.

The CRS Youth Consultant continues to serve on the National KASA Board and her efforts related to this prestigious honor will be supported by CRS.

The Youth Coordinator and Youth Consultant participate in ongoing efforts of a workgroup developing an enhanced Care Coordination Program. Transition planning and resources will be included as part of the program.

CRS continues to collaborate with the Children's Advisory Council for the MHMR, the ADRS Deaf Services Transition Committee, the MCH-UAB Network (Leadership Education in Adolescent Health [LEAH] and Leadership Education in Neurodevelopmental and Related Disabilities [LEND] programs), and the ADRS services for the Blind. Collaboration with LEND led to the development of a CD ROM, Transition of the Chronically Ill. This CD and training video was distributed to all CRS and VRS supervisors and was highlighted in the annual 2010 meeting in November 2004.

### c. Plan for the Coming Year

Direct:

In FY 2006 CRS will expand Teen Transition Clinic to at least 1 additional site.

Enabling:

CRS will facilitate youth/professional collaboration in program and policy activities through the employment and support of a State Youth Consultant, support of youth on the CRS State YAC, involvement in the National KASA Board, training activities, and articles in the Parent Connection newsletter. Youth Advisory Committee activities will include quarterly conference calls, at least 2 face-to-face meetings, and information sessions for parents of YAC members.

A notebook will be developed for youth to organize and retain information related to transition.

**Population-based:**

CRS will have youth with special health care needs as co-presenters at all staff and community training related to transition issues. Youth Power Workshops will be held in 3 new sites. CRS will continue to expand public relations materials regarding the Youth Connection Program activities and the Teen Transition Clinic and will continue to build transition resources for the CRS program.

**Infrastructure-building:**

In FY 2006, CRS will continue working with its partners and stakeholders to implement a State plan to ensure that by 2010 all youth with special health care needs will receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. CRS will continue collaboration with VRS to implement the interdepartmental plan to promote transition services for youth with special health care needs.

**Performance Measure 07:** *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	75.3	78.1	80.9	83.8	86.9
Annual Indicator	78.6	77.7	77	78.9	82.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	83.8	85.1	86.4	87.7	89

**Notes - 2002**

Values are from the National Immunization Survey conducted by the U.S. Centers for Disease Control and Prevention (CDC). Tables published by CDC do not provide numerators and denominators but show a 95% confidence interval (CI) of +/-5.0 The estimates for 1999 and onward are not comparable to estimates for 1998 or earlier years. The reason for this lack of comparability is that the only available estimates approximating this performance measure for 1998 and earlier years pertain to completed immunizations for measles, polio, diphtheria, tetanus, pertussis, and Haemophilus influenza (subsequently termed "major series") and do not include Hepatitis B. In FY 2000, targets for 2000 and 2001 were revised, and those for 2002-2005 set, to pertain to the major series plus Hepatitis B.

Targets of 90% for 2006 and 2007 have been added. During the upcoming FY 2004 needs assessment, targets from 2005 and onward may be revised downward to proceed from a 3-year baseline for 2002-2004.

### **Notes - 2003**

Values are from the National Immunization Survey conducted by the U.S. Centers for Disease Control and Prevention (CDC). Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of + or - 4.9 for Alabama in FY 2003. Estimates for 1999 and onward are not comparable to those for 1998 and earlier. The reason for this lack of comparability is that the only available estimates approximating this measure for 1998 and earlier pertain to completed immunizations for measles, polio, diphtheria, tetanus, pertussis, and Haemophilus influenza (subsequently termed "major series"). In FY 2000 targets for 2000 and 2001 were revised, and those for 2002-2005 set, to pertain to the major series plus Hepatitis B. Targets of 90% for 2006 -2008 have since been added. During the FY 2004-05 needs assessment, targets from 2005 and onward may be revised downward to proceed from a 3-year baseline for 2002-04.

### **Notes - 2004**

Values are from the National Immunization Survey conducted by the U.S. Centers for Disease Control and Prevention (CDC). Tables published by CDC do not provide numerators and denominators, which is why these items are left blank, but show a 95% confidence interval of + or - 5.3 for Alabama in FY 2004. Please see year 2002 or 2003 notes above for additional comments.

Comparing 2004 to 2000, this indicator increased by an average of 1.3% per year (based on a multiplicative model). The objectives shown for 2005 forward require an average annual improvement of 1.5%, which is somewhat greater than that experienced in recent years.

#### **a. Last Year's Accomplishments**

##### **Cross-cutting:**

The Immunization Division, located in the Department's Bureau of Communicable Disease, is basically responsible for some enabling services and for population-based and infrastructure-building services designed to promote full immunization of infants and toddlers. Activities occurring in FY 2004 (unless stated otherwise) follow and, unless otherwise indicated, were carried out by the Immunization Division.

##### **Direct:**

CHD staff immunized infants and children seen in clinics.

##### **Enabling:**

The sending of postcards to parents of 11-month-old CHD patients to remind them of vaccines that will become due after the 1st birthday continued.

##### **Population-based:**

Tracking of all infants known to be born to mothers with chronic hepatitis B, as well as household and sexual contacts of the mothers, continued. Further, the sending of vaccine pamphlets to parents of all 4-month-old infants born in the State to remind them of the importance of vaccines continued.

##### **Infrastructure-building:**

Maintenance of the Immunization Provider Registry with Internet Technology (IMMPrint) continued. This registry makes childhood vaccine histories available to all the State's vaccine providers. Many federally qualified health centers (FQHCs) in Alabama use IMMPrint.

Also continued were provision of immunization education and vaccine-completion-level audits in FQHCs and private physicians offices, provision of satellite down-link sites for programs



presented by CDC, and administration of the Vaccines for Children (VFC) Program for the State. As of early FY 2004 the Immunization Division was providing vaccine and support for 540 public and private VFC providers.

Via the Public Health of Alabama County Operations Network (PHALCON), provision of educational materials required for the Immunization Program for on-site printing by CHDs continued. These materials were available in English and Spanish. Making such materials available in this way has decreased storage needs at the central-office and county levels.

Procedures to identify CHD Child Health patients who were 4 months of age or older and had not been vaccinated continued. The groundwork for these procedures had been laid in FY 2003, when the Immunization Division retooled a computer program, run from IMMPrint, to identify these infants and children. Subsequently, in June 2003 immunization records in IMMPrint were linked directly to PHALCON, allowing CHD staff to access patient vaccination history, including vaccines provided through the private sector. CHDs were then to track Child Health Patients aged 4 months or older who had not been vaccinated, since this group of infants and children are considered least likely to complete the vaccine series.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide immunizations to infants or children seen in county health department (CHD) clinics.	X			
2. Via postcards, remind parents of 11-month-old CHD patients of vaccines that will be due soon.		X		
3. Mail vaccine pamphlets to parents of all 4-month-old infants (with available addresses) in the State.			X	
4. Maintain an immunization registry, to make childhood vaccine histories available to all providers.				X
5. Provide vaccine-level audits in federally qualified health centers and for some private providers.				X
6. Administer the Vaccines for Children (VFC) Program for the State.				X
7. Provide vaccine and support for public and private providers of VFC vaccine.				X
8.				
9.				
10.				

**b. Current Activities**

FY 2004 activities basically continue in FY 2005. The number of enrollees in the VFC Program has increased to 566, and the Immunization Division provides vaccine and support for all of these enrollees.

**c. Plan for the Coming Year**

FY 2004 and 2005 activities, recapped below, will basically continue in FY 2005.

Direct:

CHDs will continue providing immunizations to infants and children seen in clinics.

**Enabling:**

The Immunization Division will continue sending reminders to parents regarding immunizations that are due and the importance of vaccines.

**Population-based:**

The Immunization Division will continue tracking infants known to be born to mothers with chronic hepatitis B, and sending vaccine pamphlets to parents of all 4-month-old infants born in the State.

**Infrastructure-building:**

The Immunization Division will continue maintaining IMMPrint; providing immunization education and vaccine-completion-level audits; providing satellite down-link sites for programs presented by CDC; and administering the State's VFC Program.

**Performance Measure 08:** *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	41.3	38.2	36.7	35.2	33.8
Annual Indicator	36.3	30.8	29.9	27.3	27.4
Numerator	3400	2971	2899	2660	2672
Denominator	93649	96498	96896	97295	97694
Is the Data Provisional or Final?				Final	Provisional
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	26.8	26.3	25.7	25.2	24.7

**Notes - 2002**

The denominator for 2002, 2001 and years prior to 2000 represent 60% of the population projection for females aged 15-19 years in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research. The denominator for 2000 was derived from the 2000 Census of Population, SF 1 File, conducted by the Bureau of the Census, and was the population count for females aged 15-17 years in the specified calendar year.

Targets added for 2006 and 2007 are each 4.0% below the target for the year preceding it. Earlier targets are retained from the 2001 report/2003 application.

**Notes - 2003**

**Field Note:**

The denominator for 2003, 2002, 2001 and years prior to 2000 represent 60% of the population

projection for females aged 15-19 years in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research. The denominator for 2000 was derived from the 2000 Census of Population, SF 1 File, conducted by the Bureau of the Census, and was the population count for females aged 15-17 years in the specified calendar year.

Targets added, in FY 2003, for 2006 and 2007 are each 4.0% below the target for the year preceding it. Earlier targets are retained from the 2001 report/2003 application. The target for the Annual Performance Objective for 2008 has been set to that for 2007. Targets for 2005-2008 will be reconsidered, and a target for 2009 set, during the State's FY 2004-05 maternal and child health needs assessment.

#### **Notes - 2004**

Please see year 2002 or 2003 notes above for additional comments that are applicable to the denominator for 2004.

Comparing 2004 to 2001, this indicator has declined (improved) by an average of 3.9 percent per year (based on a multiplicative model). Because we are not confident that the rapid decline in this indicator will continue, objectives require a modest decline of 2.0% per year from the 2004 baseline.

#### **a. Last Year's Accomplishments**

Unless otherwise stated, all activities described below occurred in FY 2004.

##### **Direct:**

Health department family planning clinics served 29,244 teens under 20 years of age (down slightly from 29,524 in FY 2003). The decrease in the number served may have been due to Hurricane Ivan. Due to this hurricane, clinics in 36 counties were closed for 1 day and clinics in 17 counties for 3 days or more. Further, the Mobile CHD was closed for a week due to moving to a new facility.

##### **Enabling:**

ADPH care coordinators (licensed social workers and nurses trained to provide care coordination) coordinated care for 9,336 teens aged 18 years and younger. These services were provided under the Teen Care Coordination Project, continued from the preceding year and funded by DHR. The Project served teens aged 18 years or younger who were ineligible for the Plan First Program. However, the Teen Care Coordination Project was terminated September 30, 2004, due to financial shortfalls at DHR.

##### **Population-based:**

The toll-free InfoConnection hotline to provide educational information for teens on reproductive health and family planning services continued.

The Alabama Abstinence-Only Education Program (AAEP), which promotes abstinence-only until marriage, provided abstinence education to youth 17 years of age and younger. AAEP funded 9 projects that provided interventions and mentor programs to 32,000 youth in 34 counties. A statewide media campaign used billboards, press releases, and a website to educate about and promote abstinence.

The Alabama Community-Based Abstinence-Only Education Program (ACAEP) provided education on abstinence to adult role models and to youth aged 12-18 years. ACAEP funded 6 projects that provided interventions to 11,000 adults/youth in 48 cities. For this Program also, a statewide media campaign used billboards, press releases, and a website to educate about and to promote abstinence.

The Alabama Unwed Pregnancy Prevention Program (AUPPP), which had been supported by

DHR, was phased out in FY 2004. Projects within AUPPP, including community-based projects and a media campaign, were terminated effective March 30, 2004. The phasing out of AUPPP was due to the State's financial shortfall, discussed in Section III.B. In the context of this shortfall, DHR stopped providing ADPH with TANF dollars to support AUPPP, to be effective at the end of FY 2004. Further, due to ADPH's budget cuts discussed in Section III.B, FHS needed to prioritize activities and allocate resources accordingly. Thus, the Director of FHS requested and received DHR's permission to re-channel TANF dollars received by FHS in FY 2004 toward the purchase of Depo-Provera, which led to phasing out AUPPP before the end of FY 2004.

**Infrastructure-building:**

A 2-part satellite training was provided to ADPH staff on "Preventing Sexual Coercion Among Adolescents." Per ADPH policy, counseling of all teenaged CHD family planning patients on the topics of sexual coercion and parental involvement continued.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide family planning services for teens coming to CHDs for such services.	X			
2. Counsel teens coming to CHDs for family planning services, regarding how to respond to pressure to engage in sexual activity and how to avoid sexual coercion.		X		X
3. Provide care coordination for teens who come to CHD family planning clinics and are eligible for Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.		X		X
4. Operate InfoConnection, the toll-free telephone hotline that provides educational information for teens on reproductive health and family planning services.			X	
5. If receipt of federal funds continues, administer the Alabama Abstinence-Only Education Program (AAEP) to prevent teen pregnancy.			X	X
6. Through AAEP, channel federal funds to eligible community groups seeking to prevent adolescent pregnancy.			X	X
7.				
8.				
9.				
10.				

**b. Current Activities**

**Cross-cutting:**

AAEP activities are expected to basically continue throughout FY 2005. Funding for ACAEP ended on June 30, 2004, so this program has been discontinued.

**Direct:**

FY 2004 activities for serving teens in family planning clinics have continued in FY 2005.

**Enabling:**

In March 2005, 2 DHR-developed pamphlets on consensual sex and Alabama law were ordered and distributed to all clinics for family planning clients. Two other pamphlets, "20 Ways

to Respond to Sexual Pressure" and "Before You Date an Older Guy," were also provided to CHD teenaged family planning patients during counseling sessions, per ADPH protocol. A video "Crossing the Line" was adapted and produced by ADPH in December 2004, and copies have been made available to CHDs for patient viewing. This video is a series of vignettes showing different types of sexual coercion and appropriate ways to respond to such behavior.

Teen care coordination was implemented in family planning clinics in FY 2005 for teens who are EPSDT eligible. EPSDT care coordination, through which children and youth through 20 years of age can receive care coordination at CHDs, is discussed in Section III.A.

**Population-based:**

FHS's Family Planning Program is sponsoring national speakers on teen pregnancy issues for the Alabama Campaign to Prevent Teen Pregnancy and the Alabama Fatherhood Initiative Conferences.

**c. Plan for the Coming Year**

**Cross-cutting:**

Unless previously stated otherwise, FY 2004 & 2005 activities will basically continue in FY 2006. These include family planning clinical, educational, and counseling services and the toll-free hotline. Teen care coordination will also be continued for CHD teenaged family planning patients who are eligible for EPSDT. As previously stated, however, AUPPP and ACAEP were terminated in FY 2004.

**Infrastructure-building:**

AAEP plans to submit an application for federal funding to continue providing abstinence-only education to youth aged 17 and younger, and to continue providing community-based abstinence-only education. The community-based education would primarily target adult role models, as well 12-18 year-old youth in schools and communities throughout the State.

**Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	42	50	58	67	23.2
Annual Indicator	45.5	22.2	22.5	22.7	22.9
Numerator	71			384	
Denominator	156			1692	
Is the Data Provisional or Final?				Final	Provisional
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual					

Performance Objective	23.7	24.2	24.7	25.2	25.7
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## Notes - 2002

The estimate for 1991 (reported in previous reports/applications as 20.0%) is from a direct observation survey. The estimate for 2000 is a provisional estimate from the Telephone Survey of Alabama Households with Children (discussed in Section II).

Per a very preliminary estimate from an ongoing FY 2003 direct observation survey, 22.2% of Alabama public school third graders have dental sealants in place on at least 1 permanent molar tooth. Based on perception and the literature, the parental-report-based estimate for 2000 presumably markedly overestimates the proportion of children who have dental sealants. We therefore consider the estimates for 1991 and 2003 to be more reliable than the parental-report-based estimate. We have no dental sealant database for 2001 and 2002. Estimates for these years were derived by assuming a constant annual percent change, calculated as 1.1% per year, from the 1991 observation-based estimate to the 2003 observation-based estimate. Numerators and denominators are not available for these estimated percentages.

Objectives for 2004 and 2005 have been revised, and those for 2006 and 2007 set, to require an annual improvement of 5% from the very preliminary estimate for FY 2003.

## Notes - 2003

Because the estimates for 1999 (not shown on form, but also based on parental report) and 2000 are spuriously high and are not comparable to one another, they did not provide a valid basis for setting targets for this measure. Nevertheless, they were the only recent estimates available when targets were initially set, so were previously used in setting targets. Although a provisional estimate for the observation-based survey done in FY 2003 was available by July 2003, revision of targets was delayed until a final estimate would be available. This decision, as well as our practice of revising objectives only for current or future years, accounts for the wide discrepancy in estimated indicators and performance objectives for FYs 2001-2003.

## Notes - 2004

A direct-observation survey on a representative sample of 3rd graders was not conducted in FY 2004. We therefore estimated the percentage for FY 2004 by multiplying 1.01 times the observation-based percentage for FY 2003. This factor was chosen because, based on 2 observation-based point estimates, the annual rate of improvement between FYs 1999 and 2003 had been 1.1%. (Numerators and denominators are not provided for interpolated estimates, shown for FYs 2001, 2002, and 2004.) Interpolated estimates will be provided until another statewide, direct-observation survey of dental sealants in 3rd graders is conducted, which is expected to occur in FY 2006.

The reason for wide disparities in objectives and performance for FYs 2001-2003 is described in notes to FY 2003. From 2001 forward, targets require an annual improvement of 2.1% per year--a modest improvement, but twice that of the estimated historical rate of improvement of 1.1% per year.

### a. Last Year's Accomplishments

The following activities occurred in FY 2004.

#### Cross-cutting (Direct and Infrastructure-building Services):

Through an oral health grant administered through the U.S. Health Resources and Services Administration's (HRSA's) Maternal and Child Health Bureau (MCHB), in FY 2004 a broader and more comprehensive dental program was provided in Escambia County, a rural county in south Alabama. Sealant data collected from kindergarten through 12th grade children in this county indicated that only 8.0% (352/4,400) had dental sealants on a permanent molar. This prevalence is much lower than that for 3rd grade children in the State as whole, which was

22.7% (67/1,692) in FY 2003, per a direct-observation, oral health survey conducted in 25 public schools on a representative sample of Alabama school children.

OHB staff and UAB School of Dentistry (School of Dentistry) pediatric residents followed up on the survey by offering dental sealants to 333 qualifying 2nd grade children in Escambia County. Portable dental equipment was set up in each of the qualifying schools, and about 479 sealants were placed on 192 of the eligible children, who had parental consent and had no private dental provider.

Population-based:

A flurry of activities surrounded National Children's Health Month. Press releases and television interviews stressed the importance of starting good oral health practices for children when they are 1 year of age. The national Give Kids a Smile Campaign involved collaborative efforts with a district dental society to identify children in urgent need of dental care.

Infrastructure-building:

The Alabama Medicaid Dental Task Force produced articles concerning dental sealants, which were published in the Medicaid newsletter.

OHB continued donating disposable sealant supplies, instruments, and small equipment for school-based dental clinics that provided services for qualifying children on free and reduced lunch programs.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In collaboration with others and as opportunities and funds arise, provide dental services (including application of dental sealants when indicated) to certain populations of children who tend to have unmet dental needs.	X			X
2. Conduct periodic direct-observation surveys of oral health in school children--contingent on availability of funds, partnership with other oral health professionals, and support of the school system.	X			X
3. Participate in National Children's Health Month.			X	
4. Participate in the national "Give Kids a Smile" campaign.			X	
5. Whenever indicated, collaborate with Medicaid to increase awareness among dental professionals and the public regarding the importance of dental sealants.			X	X
6. Donate dental sealant supplies, instruments, and small equipment to certain school-based dental clinics.				X
7.				
8.				
9.				
10.				

**b. Current Activities**

The following activities occurred in FY 2005.

Direct:

A 2-chair mobile dental van was used to screen and treat children in their school environment. This service became possible because a Birmingham dentist purchased the van and volunteered it for collaborative projects with the Health Department and the School of Dentistry. The van was purchased as part of a faith-based initiative, Smiles-of-Grace. The first use of the van occurred during National Dental Health Month, when the van's owner joined the Health Department and the Tuscaloosa Dental District Society for the Give Kids a Smile Campaign.

**Population-based:**

OHB again participated in activities pertaining to National Children's Health Month and the Give Kids a Smile Campaign.

**Infrastructure-building:**

Through additional funds received through MCHB in FY 2005, current activities include the addition of a PHA nurse to continue assisting OHB and School of Dentistry staff in collecting dental sealant and dental disease prevalence data. About 98% of school children in 3 additional rural south Alabama counties (Conecuh, Lowndes and Monroe) have received oral health assessment thus far in FY 2005. In these counties, which have a large percent of children on free or reduced lunch compared to the State as a whole, only 10% of school children were found to have dental sealants on at least 1 permanent molar. In May 2005 the dental team surveyed Escambia County 2nd and 3rd grade children again to compare data and to evaluate sealant retention rates on 2nd graders participating in the FY 2004 school-linked sealant program.

OHB staff wrote an article concerning underutilization of dental sealants despite substantial reimbursement by 3rd-party payers in the State, which was published in the Alabama Dental Association newsletter.

Donation of supplies and equipment to school-based clinics continued as described under "Last Year's Accomplishments."

**c. Plan for the Coming Year**

**Cross-cutting (Direct and Infrastructure-building services):**

Unless previously stated otherwise, FYs 2004 & 2005 activities will basically continue in FY 2006. The Alabama Medicaid Dental Task Force will evaluate the need for more educational materials concerning sealants. Additionally planned for FY 2006 is another statewide, direct-observation oral health assessment. Previously described donation of supplies and equipment to school-based dental clinics will continue, as funding permits.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	8.1	8	7.8	7.7	7.5
Annual Indicator	5.5	6.3	6.1	5.4	6.5



Numerator	51	59	57	50	61
Denominator	931589	932478	933368	934255	935145
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	6.4	6.2	6	5.9	5.8

#### Notes - 2002

The denominator for 2002, 2001 and years prior to 2000 represent the population projection for children 14 years of age and younger in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research. The denominator for 2000 was derived from the 2000 Census of Population, SF 1 File, conducted by the Bureau of the Census, and was the population count for children 14 years of age and younger in the specified calendar year.

International Classification of Diseases, Tenth Revision (ICD-10) codes were used for 1999 through 2002, while International Classification of Diseases, Ninth Revision (ICD-9) codes were used for earlier years. Thus, estimates for 1999 through 2002 may not be comparable to those for previous years.

Targets added for CY 2006 and 2007 require an annual decline of 2.0% from the 3-year baseline of 6.6 deaths per 100,000 in 1999-01. Earlier targets are retained from previous MCH Block Grant reports/applications.

#### Notes - 2003

Field Note:

The denominator for 2003, 2002, 2001 and years prior to 2000 represent the population projection for children 14 years of age and younger in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research. The denominator for 2000 was derived from the 2000 Census of Population, SF 1 File, conducted by the Bureau of the Census, and was the population count for children 14 years of age and younger in the specified calendar year.

International Classification of Diseases, Tenth Revision (ICD-10) codes were used for 1999 through 2003, while International Classification of Diseases, Ninth Revision (ICD-9) codes were used for earlier years. Thus, estimates for 1999 through 2003 may not be comparable to those for previous years.

The estimate for 2003 is rough and very provisional, and additional deaths may yet be reported. In particular, death certificates for any Alabama residents who died in Mississippi have not yet been received.

Targets added, in FY 2003, for CY 2006 and 2007 require an annual decline of 2.0% from the 3-year baseline of 6.6 deaths per 100,000 in 1999-01. Earlier targets are retained from previous MCH Block Grant reports/applications.

The target for Annual Performance Objective for 2008 has been set to that for 2007. Targets for 2005-2008 will be reconsidered, and a target for 2009 set, during the State's FY 2004-05 maternal and child health needs assessment.

#### Notes - 2004

Please see year 2002 or 2003 notes above for additional comments that are applicable to the denominator for 2004.

ICD-10 codes were used for 2004.

Comparing 2003-04 to 2000-01, this indicator increased (worsened) by an average of 0.2% per year (based on a multiplicative model). Attaining the 2009 objective of 5.8 deaths per 100,000 children in the age group will require an average decline of 0.5% per year from the 2004 baseline (multiplicative model), which is fairly aggressive given the preceding, though small, increase. The objective for 2005 was set by subtracting 0.1 from the 2004 baseline, and objectives for 2006-2008 were set by subtracting 0.1 or 0.2 from the previous year's objective.

#### a. Last Year's Accomplishments

##### Infrastructure-building:

In FY 2004 ACDRS continued reviewing all unexpected or unexplained infant and child deaths per the mandating legislation, described in Section III.B. The collected ACDRS data confirmed that vehicle-related deaths remained the most common cause of preventable child deaths in Alabama. The state's law enforcement agencies conducted another Click It or Ticket campaign, which ACDRS supported. The 3rd set of ACDRS recommendations to the Governor, submitted in 2004, repeated previous recommendations that increased attention be given to safety concerns regarding operation of all-terrain vehicles by children and the transport of children on public roads in pickup truck beds. Additionally, ACDRS supported proposed legislation that would require children and youth up to the age of 16 years to use approved safety restraints regardless of seat position. HPCD's Injury Prevention Division conducted its annual observational surveys of occupant restraint use.

The Alabama Graduated Driver's License legislation, which took effect in October 2002, continued to be operative. Under this law, restrictions apply to 16-year-old drivers and to 17-year-old drivers who have been licensed for less than 6 months. Restricted drivers cannot have more than 4 passengers, not counting their parents, in the car. Additionally, except under certain circumstances, they cannot drive between midnight and 6 A.M. unless accompanied by a parent, guardian or, with the consent of the parent/guardian, a licensed adult driver. The circumstances in which they do not need to have a parent/guardian or licensed adult designee of the parent/guardian with them are when the teenager is driving to or from work or a school or church event or driving due to an emergency.

In FY 2004 HPCD's Injury Prevention Division again conducted the Alabama Observational Survey of Occupant and Child Restraint Use, with 64,279 front seat occupants and 1,888 children 5 years of age and younger being surveyed. Findings were that 80.0% of front seat occupants and 82.9% of children were in restraints. The national usage rate for FY 2004 was 80%.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Alabama Child Death Review System (ACDRS), to review unexpected deaths of children and youth.				X
2. [Appropriate State authorities] enforce the graduated drivers's license law.				X
3. Through ACDRS, monitor deaths of infants, children, and youth due to motor vehicle crashes.				X

4. As indicated, provide recommendations to governing entities regarding road safety issues.				X
5. Implement an annual survey of occupant restraint use.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

In FY 2005 ACDRS continues monitoring all unexpected or unexplained infant and child deaths in Alabama per the mandating legislation, including those caused by motor vehicle crashes. To our knowledge, no action has been taken by the Governor or State Legislature pertaining to ACDRS's recommendations regarding operation of all-terrain vehicles by children and the transport of children on public roads in pickup truck beds. The previously mentioned legislation proposed in FY 2004 to require children and youth up to the age of 16 years to use approved safety restraints regardless of seat position has not passed, but is being pursued once more during this legislative year. In FY 2005, in their 4th set of recommendations to the Governor, ACDRS will repeat recommendations regarding children and all-terrain vehicles, children in the rear of pickup trucks, and the need for improved auto safety restraint laws for vehicular passengers 16 years of age and younger. HPCD's Injury Prevention Division continues conducting annual observational surveys of occupant restraint use.

The Alabama Graduated Driver's License legislation continues in effect.

#### c. Plan for the Coming Year

Infrastructure-building:

In FY 2006 ACDRS will continue reviewing all unexpected or unexplained infant and child deaths per the mandating legislation and following up on previously described recommendations to the Governor. HPCD's Injury Prevention Division will continue conducting annual observational surveys of occupant restraint use.

The Alabama Graduated Driver's License legislation will continue to be in effect.

#### Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	66.2	45.9	47.3	48.7	50.2
Annual Indicator	47.3	50.7	48.0	51.8	
Numerator	28644	27725	26873	27291	

Denominator	60580	54701	55995	52641	
Is the Data Provisional or Final?				Final	
	2005	2006	2007	2008	2009
Annual Performance Objective	53.9	55	56.1	57.2	58.4

#### Notes - 2002

See note to 2004 for discussion of the data source, which is the Pregnancy Risk Assessment and Monitoring Systems (PRAMS).

#### Notes - 2003

See note to 2004 for discussion of the data source, which is the Pregnancy Risk Assessment and Monitoring System (PRAMS).

#### Notes - 2004

Estimates for this indicator are for calendar year and are from Pregnancy Risk Assessment Monitoring System (PRAMS) data, which are managed by the U.S. Centers for Disease Control and Prevention (CDC). The PRAMS survey is a population-based mail/telephone survey of Alabama residents who recently gave birth in the State. A stratified complex sampling design is used, and numbers reported here are weighted to represent all live births occurring in Alabama to Alabama residents. The percentage of mothers who were breastfeeding at 1 week postpartum was used as a surrogate for the percentage breastfeeding at hospital discharge. The PRAMS question did not distinguish between exclusive breastfeeding and breastfeeding with supplemental feedings. Because data are based on a sample rather than the total number of births, some statistical imprecision is expected. Observations for which breastfeeding status is unknown or unreported are included in the denominators, which yields conservative estimates.

Due to the time required for the data management process (which includes weighting and preparation of data), data for a given year do not generally become available to the states until at least 1 year 4 months after the end of the data collection year. For example, data for 2000 were made available by around May 2002 and could be reported in the MCH Block Grant submitted in July 2002. Under this type of time frame, though we cannot provide an estimate for this indicator for the reporting year, we can provide one for the year preceding the reporting year--in this case, 2003. When the U.S. Centers for Disease Control and Prevention (CDC) provides the State with the PRAMS database for 2004, the Alabama Department of Public Health's Center for Health Statistics will promptly provide estimates for this performance measure to the Bureau of Family Health Services, who will update Form 11 at the first opportunity.

Comparing 2002-03 to 1999-00, this indicator increased (improved) by an average of 2.1% per year (based on a multiplicative model). The objectives for 2005-2009 require an annual increase of 2.0% per year, from the 2003 baseline.

The previously set objective for 2004, which was surpassed in 2003, is retained since that year has passed. Family Health Services is seeking, however, to promote further improvement in this indicator.

#### a. Last Year's Accomplishments

All of the following occurred in FY 2004.

Population-based:

WIC continued to increase public awareness of the importance of breastfeeding. For instance, radio ads to promote breastfeeding, targeting working mothers and emphasizing family support, were aired statewide during Breastfeeding Awareness Month.

#### Infrastructure-building:

The Breastfeeding Coordinator continued training WIC staff and offering breastfeeding education to staff from Alabama hospitals. Breastfeeding education presentations were made at CHDs or local hospitals, with staff from various hospitals and physicians' offices attending.

The WIC Breastfeeding Coordinator served as a board member of the Alabama Breastfeeding Coalition, which held the statewide breastfeeding conference in Birmingham. About 100 health professionals attended.

The Annual WIC Nutrition Education and Breastfeeding Promotion Workshop had 2 sessions on breastfeeding topics and was attended by 75 Health Department staff members.

WIC continued sending a quarterly infant breastfeeding report, generated from WIC data, to PHA Nutrition Coordinators. The report listed breastfeeding initiation and duration rates for each clinic and PHA.

Fifty-seven percent of hospitals responded to the annual Hospital Breastfeeding Survey.

The Breastfeeding Resource Guide was updated.

Infrastructure grant funds to help increase initiation and duration rates among Hispanic populations in Pike, Barbour and Coffee County were awarded. Another breastfeeding infrastructure grant was used to train Dallas and Montgomery counties on the topic "Using Loving Support to Build a Breastfeeding-Friendly Community". The breastfeeding infrastructure grant was awarded under the auspices of a national training, technical assistance, and implementation project that is a collaboration among USDA Food and Nutrition Service, Best Start Social Marketing, and the Mississippi State Department of Health WIC Program--for the purpose of increasing breastfeeding initiation and duration rates.

Congress awarded funding for the Breastfeeding Peer Counselor Program. USDA's national budget included earmarked funding for this program. Through USDA, the Alabama WIC Program received approximately \$198,000 to design, build and maintain a peer counseling program to improve breastfeeding initiation and duration rates.

In collaboration with CDC, CHS administered the Pregnancy Risk Assessment Monitoring System (PRAMS) for Alabama. This system collects information on breastfeeding, as well as many other issues concerning pregnancy and infancy.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote public awareness of the importance of breastfeeding, through billboards or other appropriate media.			X	
2. Collaborate with the Alabama Breastfeeding Coalition and, when indicated, other groups to promote breastfeeding.			X	X
3. Present breastfeeding education programs for CHD staff and, upon request, hospitals.				X

4. Send a quarterly infant breastfeeding report, based on WIC data, to Public Health Area Nutrition Coordinators.				X
5. Implement and expand the Breastfeeding Peer Counselor Program.			X	X
6. Post the Annual Breastfeeding Resource Guide on Alabama WIC's website.			X	
7. Develop and implement a strategic breastfeeding plan for Alabama communities.			X	X
8.				
9.				
10.				

#### b. Current Activities

FY 2004 activities have basically continued in FY 2005. The one exception, as well as updates describing FY 2005 activities, follows. Activities are organized according to the MCH pyramid level of service that they mainly involve.

##### Population-based:

The Annual Breastfeeding Resource Guide can now be accessed through Alabama WIC's website.

Billboards to promote breastfeeding in Mobile, Montgomery, and Birmingham, 3 of the State's metropolitan areas, will be purchased for viewing from July through September 2005.

##### Infrastructure-building:

The Alabama Breastfeeding Coalition will not have a statewide conference in FY2005. A Breastfeeding Task Force was formed, and in July a breastfeeding conference for health professionals will be held in partnership with UAB.

A training entitled "Using Loving Support to Build a Breastfeeding-Friendly Community" was provided by Best Start Social Marketing in March 2005, with 37 attendees from community groups, hospitals, physicians' offices and CHDs. A strategic plan will be developed from this training to promote breastfeeding in Alabama communities.

The June 2004, the State Breastfeeding Coordinator and WIC Director attended the USDA training "Using Loving Support to Manage Peer Counseling Programs." The State Plan for Peer Counseling was approved. This training helped lay the groundwork for initiating pilots of peer counseling programs to improve breastfeeding initiation and duration rates. To further lay the groundwork, an additional training, entitled "Loving Support Through Breastfeeding Peer Counseling," was provided by Best Start Social Marketing April 2005. This training utilized a train-the-trainer approach for the State Breastfeeding Coordinator and three CHD staff to implement a Peer Counseling Program concerning breastfeeding. Three clinics will begin piloting such programs in FY 2005.

The Annual Breastfeeding Resource Guide can now be accessed through Alabama WIC'S website.

#### c. Plan for the Coming Year

##### Crosscutting (Population-based, Infrastructure-building):

Unless previously stated otherwise, FYs 2004 and 2005 activities will basically continue in FY 2006. These include:

- 1) Implementation of the Breastfeeding Peer Counselor program, which will be expanded.

- 2) Implementation of a strategic breastfeeding plan for Alabama communities.
- 3) Training of WIC staff, as well as offering of breastfeeding education statewide.
- 4) Provision of the Annual WIC Nutrition Education and Breastfeeding Promotion Workshop.
- 5) Administration of PRAMS for Alabama.

Further, Loving Support Three Step Counseling will be provided statewide, to enhance breastfeeding promotion efforts. The Breastfeeding Task Force will hold a Breastfeeding Summit for physicians in December 2005.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	70	74.7	79.7	85	87.5
Annual Indicator	72.9	84.0	93.4	95.6	88.2
Numerator	45576	50186	54000	55846	51459
Denominator	62534	59768	57839	58397	58369
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	90	92.9	95	95	95

#### Notes - 2002

This estimate is very rough. See note for 2003.

#### Notes - 2003

Numerators for 2002 and 2003 are based on hospitals performing screenings in calendar years 2002 and 2003. However, the estimate for 2002 is very rough, since the current reporting system (based on reports from individual hospitals participating in the Newborn Hearing Screening Program) did not begin until December 2002. Further, the numerator for 2003 was estimated by multiplying the estimated number of live births in 2003 (56,986) in hospitals participating in the Newborn Hearing Screening Program by .98. The factor of .98 is applied to allow for failure to screen a few infants in participating hospitals due to equipment failure or other issues. (Based on contacts with and reports submitted by participating hospitals, the Newborn Hearing Screening Coordinator estimates that at least 98% of live-born infants in these hospitals undergo hearing screening prior to discharge.)

Prior to 2002, numerators were based on telephone surveys, conducted by the Birmingham Ear

Institute (BEI), of hospitals to ascertain whether they screened newborns for hearing impairment and, if they did, what groups they screened. (For example, if a hospital screened no newborns, it contributed nothing to the numerator; if it screened only newborns in its neonatal intensive care unit, it contributed the number of infants in its neonatal intensive care unit during a given year to the numerator.) The denominator for each year is the number of occurrent live births in a given year or, in one case (1998), the preceding year. The estimates for 1998 and 1999 are respectively from telephone surveys conducted in March and June 1999. Those for 2000 and 2001 are from surveys conducted in April 2000 and May 2001, respectively.

Because of the dramatic improvement in this indicator in 1998, in 1999 targets for that year and subsequent years were revised upward, to reach 85% by 2003. Subsequent targets were set to reach a 90% level by 2005. Targets added, in FY 2003, for 2006 and 2007 require an average annual increase of 2.2%, from the running 3-year baseline for 2001 (i.e., 83.1% for 2000-02 combined); and the target for 2007 is retained for 2008. Targets for 2005-2008 will be reconsidered, and a target for 2009 set, during the FY 2004-05 maternal and child health needs assessment.

#### **Notes - 2004**

During the calendar year (CY) 2004, the Newborn Hearing Screening Program had technical difficulties in generating accurate reports (Hospital Hearing Screening Summary Reports upon which the numerator for this indicator is based). The numbers reported are not including approximately 5,000 babies that were born during the calendar year. However, results obtained from hospitals at a later date have allowed us to document that the infants were screened before hospital discharge. Please see year 2003 for additional comments.

See note to 2003 estimate for a description of how objectives were set through 2008. The objective for 2004 was surpassed slightly, but previously set objectives for 2005-2008 remain appropriate. The objectives for 2007-2009 assume that attaining a status higher than 95% may not be feasible in the near future. If future developments indicate that surpassing 95% may be feasible after all, objectives will be revised accordingly.

#### **a. Last Year's Accomplishments**

##### **Historical context:**

Alabama's Listening, Alabama's Universal Newborn Hearing Screening Program (UNHS) has been very successful in implementing universal newborn hearing screening programs throughout the State. Hospitals began reporting hearing screening results on the blood spot form on October 23, 2002, and tracking of infants for hearing loss began at this time. All of Alabama's 59 birthing hospitals have voluntary UNHS programs in place.

In FY 2004, many activities continued to the program's continued success. Some of these follow.

##### **Enabling:**

ADPH continued to have a Universal Newborn Hearing Screening (UNHS) Coordinator on staff. The UNHS Coordinator tracks infants who do not pass or did not have a hearing screening to ensure they receive appropriate follow-up services. Tracking and follow up includes letters to parents and primary care providers, followed by telephone calls to parents and primary care providers to obtain follow-up hearing screening or diagnostic evaluation results.

##### **Infrastructure-building**

The Qualified Provider Directory was completed and distributed to every pediatrician and audiologist in the State in April 2004. This directory lists audiologist by perinatal region and county who can provide diagnostic and amplification services to infants.

To reduce the number of infants leaving the hospital without a hearing screening, equipment continued to be loaned to hospitals when their equipment was being repaired.



ADPH continued providing monthly statistical reports concerning each hospital participating in the newborn hearing screening program. These reports include: number of infants born, number screened, number who pass screening, number who do not pass screening, and the number for whom screening was missed or refused. Each hospital is provided with the hospital's individual results and with statewide results.

ADPH continued to contract with the Alabama Ear Institute to have on staff a Universal Newborn Hearing Screening Resource Coordinator. This coordinator provided education and technical assistance to health care providers and coordinated family-oriented support programs like the Parent-2-Parent Network (P2P), which had been formed in August 2000.

In December 2003 the ADPH's Care Coordination Program began providing case management services for the UNHS Program to Medicaid-enrolled infants. There are care coordinators in all of the state's 67 counties. They contact parents, primary care providers, and hospitals in their respective counties to obtain information regarding hearing screening and follow-up status. The care coordinators provide this service through telephone calls, letters, and home visits.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement the State's Universal Newborn Hearing Screening Program (UNHSP).	X	X	X	X
2. Track infants who do not pass or did not have a hearing screening to ensure they receive appropriate follow-up services.		X		X
3. Distribute the Qualified Provider Directory, which lists audiologists who can provide diagnostic and amplification services to infants.				X
4. When equipment belonging to a hospital participating in UNHSP is being repaired, loan equipment for newborn hearing screening to the hospital.				X
5. For each participating hospital, provide monthly statistical reports tabulating the number of newborns who had hearing screening and the results of screenings.				X
6. Provide care coordination for the UNHS Program to Medicaid-enrolled infants.		X		X
7. As indicated and feasible, provide hands-on equipment training to all hospital staff members providing newborn hearing screening.				X
8.				
9.				
10.				

#### b. Current Activities

Cross-cutting (Enabling and Infrastructure-building):

FY 2004 activities have basically continued in FY 2005. Further, in September 2004 the UNHS program contracted with Auburn University. This contract provides a doctoral-level audiology student assistant who works 10 hours a week under the direction of the UNHS Coordinator. The student assistant provides follow-up services and hospital training. The UNHS Coordinator and the audiology doctoral student developed a hospital training program to target hospitals identified as not meeting the goals of the program. This program provides an overview of the

importance of newborn hearing screening and of the early identification of hearing loss. A hands-on equipment training is provided to all hospital staff members providing newborn hearing screening. Continuing education credit has been made available for these training sessions.

### c. Plan for the Coming Year

Cross-cutting (Enabling and Infrastructure-Building):

Unless previously stated otherwise, FYs 2004 & 2005 activities will basically continue in FY 2006. However, in FY 2006 ADPH will discontinue the contract with the Alabama Ear Institute.

### Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	11.7	11.5	11.3	11.1	8.6
Annual Indicator	8.5	8.8	10.8	8.6	
Numerator	98000	101000	122000	95000	
Denominator	1158000	1143000	1128000	1101000	
Is the Data Provisional or Final?				Final	
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	8.5	8.4	8.4	8.3	8.3

#### Notes - 2002

Reference for estimates is Historical Health Insurance (HHI) Table 5, as available from a U.S. Census web site on April 2, 2003. Because the reference rounds numbers of children to thousands, percentages calculated by the web-based reporting package for this report/application sometimes differ slightly (by 0.1) from estimates shown in Census Bureau tables. (For example, HHI Table 5 reports percentages of 10.7 and 8.8 for 1999 and 2001 respectively.)

HHI Table 5 does not yet include estimates for 2002. When estimates for 2002 are provided on Table 5, this report/application will be updated accordingly.

The mean of the estimates for 1999-01 combined is 9.3%. Considering this the baseline for 2000, targets for 2004 and 2005 have been revised, and targets for 2006 and 2007 added, to require an annual reduction of 2.0%. However, targets may again be revised in FY 2004 after obtaining an estimate for 2002 and consulting with State Children's Health Insurance staff.

#### Notes - 2003

Reference for estimates is Historical Health Insurance (HI) Table 5, as available from a U.S.

Census web site on March 29, 2004. Because the reference rounds numbers of children to thousands, percentages calculated by the web-based reporting package for this report/application sometimes differ slightly from estimates shown in Census Bureau tables. (For example, Table HI-5 reports a percentage of 8.9 for 2001.)

Table HI-5 does not yet include estimates for 2003. When estimates for 2003 are provided on Table HI-5, this report/application will be updated accordingly.

The mean of the estimates for 1999-01 combined is 9.3%. Considering this the baseline for 2000, targets for 2004 and 2005 were revised in FY 2003, and targets for 2006 and 2007 added, to require an annual reduction of 2.0%. The mean of the estimates for 2000-02 combined is 9.4%

The target for 2007 has been retained for 2008. Targets for 2005-2008 will be reconsidered, and a target for 2009 set, during the FY 2004-05 maternal and child health needs assessment.

#### **Notes - 2004**

Reference for estimates is Historical Health Insurance (HI) Table 5, obtained from a U.S. Census web site on June 17, 2005. Table HI-5 does not yet include estimates for 2004. When estimates for 2004 are provided on Table HI-5, this report/application will be updated accordingly.

Please see year 2002 or 2003 for additional comments.

We have retained the objective for 2004, which was met in 2003. Comparing 2002-03 to 1999-00, this indicator declined (improved) by an average of 0.6% per year (based on a multiplicative model). Even with ongoing, intensive efforts to enroll eligible children and youth in the State Health Insurance Program or in Medicaid, increasing this rate of improvement may not be feasible. Further, the estimate for this indicator is sometimes unstable, as shown by the spike (to 10.8%) in 2002. Accordingly, objectives for 2005 onward require an average annual decline of 0.6% per year from the objective for 2004 (8.6), the same as that experienced recently. Because objectives are carried to only 1 decimal, they sometimes remain the same for 2 successive years.

#### **a. Last Year's Accomplishments**

Continuing crosscutting activities:

SCHIP's Regional Directors liaised among ADPH central-office staff and families and facilitated local efforts to enroll children. A social worker assisted the families. SCHIP's Hispanic Outreach Coordinator liaised with Hispanic/Latino communities. Applications and brochures were available in Spanish, and Spanish-speaking enrollment workers were generally available. SCHIP is further discussed in Section III.A.

Population-based:

In FY 2004 combined applications for ALL Kids/SOBRA Medicaid continued being available from CHDs and other places, a toll-free phone number, and the ALL Kids website. School outreach continued.

Due to limited State match funding, in October 2004 SCHIP instituted a waiting list for enrollment. Due to the waiting list, outreach focused more on enrollment retention, health education, and injury prevention. The waiting list was opened 7 times in FY 2004, however, and 14,476 children were enrolled during these open periods. No enrollee experienced more than 4.5 months delay due to the waiting list. Radio and television media campaigns were reinstated in June 2004. When the waiting list ended in August 2004, outreach shifted back to more aggressive outreach and enrollment but still included health education. Included in outreach were efforts, which had been increased in FY 2003, to enroll eligible children from birth to 5 years of age.

SCHIP installed a new 24/7 automated voice telephone system that allows families to select from information options or leave messages. Customer service hours of operation were expanded to 11 hours a day during the business week.

**Infrastructure-building:**

The ALL Kids Enrollment Unit included a SOBRA Medicaid eligibility determination unit that had been placed there by Medicaid in FY 2002. These Medicaid staff processed some applications that otherwise would have been processed by SOBRA Medicaid workers around the State.

FY 2004 was the 2nd year of the federal State Planning Grant. In FY 2004 several possible health plans were chosen for economic modeling and then subjected to this modeling. Additionally, a publication on the uninsured in Alabama was printed and distributed.

FY 2004 was the 2nd and final year of the Robert Wood Johnson Supporting Families After Welfare Reform (RWJ Welfare Reform Support) Grant. Under this project, SCHIP developed and piloted a web-based joint application form for SCHIP, SOBRA Medicaid, Medicaid for Low-Income Families, and the Alabama Caring Foundation--which was piloted in August 2004 and implemented statewide in September 2004.

In FY 2004 SCHIP was granted additional RWJ funds, for the Covering Alabama Kids and Families Project. The project supported efforts in the State in connection with the annual Cover the Uninsured Week. Additionally, preparations were made to further coordinate and simplify enrollment in SCHIP and in Medicaid.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer Alabama's SCHIP, which is also called ALL Kids.		X	X	X
2. Include supplemental insurance in SCHIP for enrolled CYSHCN.		X		X
3. Provide outreach that is tailored to the needs of SCHIP enrollees, SCHIP's capacity to add new enrollees, and public awareness of SCHIP.			X	X
4. In particular, outreach to the Hispanic/Latino community to provide information, including materials written in Spanish, about SCHIP.		X	X	X
5. As part of outreach, operate a 24/7 voice telephone system.			X	
6. Implement a web-based joint application form for ALL Kids, 6th Omnibus Budget Reconciliation Act (SOBRA) Medicaid, Medicaid for Low-Income Families, and the Alabama Caring Foundation.			X	
7. Provide joint application forms for ALL Kids and SOBRA Medicaid through CHDs, private health care facilities, other locations, a toll-free number, and the ALL Kids website.		X	X	X
8. Administer the Robert Wood Johnson project, Covering Alabama Kids and Families.				X
9.				
10.				

**b. Current Activities**

SCHIP's FY 2004 activities basically continue in FY 2005.

### c. Plan for the Coming Year

Unless indicated otherwise below or in previously stated time frames, SCHIP's FY 2004-05 activities will basically continue in FY 2005. Recaps of certain activities follow.

#### Cross-cutting:

SCHIP's 9 Regional Coordinators will continue engaging in health education activities and facilitating local efforts to identify and enroll SCHIP-eligible children.

The RWJ project, Covering Alabama Kids and Families, will continue.

#### Enabling:

SCHIP Regional Coordinators will continue liaising among ADPH central-office staff, health care providers, employers, and families. Provision of assistance to families by a social worker and provision of information in Spanish will continue.

#### Population-based:

SCHIP will continue providing joint application forms through CHDs, private health care facilities, other locations, a toll-free number, and the ALL Kids website. School outreach and other appropriate marketing and outreach will continue.

#### Infrastructure-building:

Out-stationing of a SOBRA Medicaid eligibility determination unit in the SCHIP office is expected to continue.

**Performance Measure 14:** *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	88	88.9	89.8	90.7	90.8
Annual Indicator	84.5	87.2	88.3	85.9	87.1
Numerator	301947	339536	379969	386624	403378
Denominator	357177	389499	430507	449906	463226
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	87.3	87.6	87.9	88.1	88.4

#### Notes - 2002

Selecting a denominator for this measure continues to be exceptionally problematic. Because suitable denominators could not be estimated from available age and poverty distributions, the

number of Medicaid-enrolled children, per Medicaid eligibility files, were used as denominators for the 1998, 1999, 2000, 2001 and 2002 estimates. Thus, the estimates shown for these years almost certainly overestimate the proportion of potentially Medicaid-eligible children who received a service paid by the Medicaid Program during the respective reporting years, and we have very limited confidence in the estimates. The numerator was estimated from tables provided by the Alabama Medicaid Agency showing numbers of Medicaid recipients of medical care for several age groups of children. Factors were applied when necessary to make estimates for an age group not precisely coinciding to the age group reported on the Medicaid tables. (The 1996 estimate was made via a different method, so is not comparable to the later estimates. A current source for estimating the denominator as it was estimated for 1996 is not available.) As is fully discussed in the narrative for this measure, the problematic denominator may mask progress in the provision of services to Medicaid-eligible children.

In 2000-2002 combined, an estimated 86.8% of potentially Medicaid-eligible children received a Medicaid-funded service. Using this as the 3-year running baseline for 2001, targets for 2004 and 2005 have been revised, and those for 2006 and 2007 set, to gradually increase to 95% in 2007. These new or revised targets require an annual increase of 1.5%, from the running baseline for 2001.

### **Notes - 2003**

Selecting a denominator for this measure continues to be exceptionally problematic. Because suitable denominators could not be estimated from available age and poverty distributions, the numbers of Medicaid-enrolled children, per Medicaid eligibility files for the respective years, were used as denominators for the 1998, 1999, 2000, 2001, 2002 and 2003 estimates. Numerators were estimated from tables provided by the Alabama Medicaid Agency for respective years, showing numbers of Medicaid recipients of medical care for several age groups of children. Factors were applied when necessary to make estimates for an age group not precisely coinciding to the age group reported on the Medicaid tables. (The 1996 estimate [not shown on Form 11 of this application/report] was made via a different method, so is not comparable to the later estimates.) The problematic denominator may mask progress in the provision of services to Medicaid-eligible children.

In 2000-2002 combined, an estimated 86.8% of potentially Medicaid-eligible children received a Medicaid-funded service. Using this as the 3-year running baseline for 2001, in FY 2003 targets for 2004 and 2005 were revised, and those for 2006 and 2007 set, to gradually increase to 95% in 2007. These new or revised targets require an annual increase of 1.5%, from the running baseline for 2001.

The target for 2007 has been retained for 2008. Targets for 2005-2008 will be reconsidered, and a target for 2009 set, during the FY 2004-05 maternal and child health needs assessment.

### **Notes - 2004**

Please see year 2002 or 2003 notes above for additional comments that are applicable to the denominator for 2004.

Comparing 2003-04 to 2000-01, this indicator increased (improved) by an average of 0.2% per year (based on a multiplicative model). Objectives for 2005 onward require an average annual increase of 0.3% per year, from the 2004 baseline.

#### **a. Last Year's Accomplishments**

##### **Backdrop:**

This background information is more fully discussed in Section III.A. Over a period of several years the number of children receiving Title V-funded services in CHDs has markedly declined. Much of the decline was concurrent with implementation of Patient 1st, Medicaid's PCCM, which many believe has increased access to primary care for Medicaid recipients, including children, throughout the State. With this increased access, many Medicaid-enrolled children

and youth who may otherwise have received direct health care at CHDs received their care elsewhere. Though providing direct care to fewer children, ADPH seeks to facilitate enrollment of Medicaid-eligible children in Medicaid (see NPM #13) and promote the provision of needed health services to these children.

Unless otherwise stated, the following activities occurred in FY 2004.

**Direct:**

CHDs provided child health services to 39,831 patients.

Subcontracts were in place in 18 counties to provide home visits to infants and postpartum patients by social workers and nurses.

Public health nurses from 7 counties in different PHAs provided school health services. Public health nurses in 3 counties provided 1,022 off-site EPSDT screening assessments.

**Enabling:**

Under the Healthy Child Care Alabama Program, 8 Child Care Nurse Consultants worked with childcare providers, children 0-5 years of age who received out-of-home childcare, and the families of these children. These services were provided in 40 counties. Further, in these counties the Child Care Nurse Consultants provided programs and information on health and safety topics and assisted in linking families and providers with community and support resources, including ALL Kids and Medicaid. In FY 2004, 4,118 referrals and/or application forms for All Kids and Medicaid were provided by Healthy Child Care Alabama Program staff.

Social Work and Nurse Care Coordinators were available in every CHD to work with patients to assist in the removal of barriers to health care. When provided to children and their families, care coordination services help facilitate enrollment of Medicaid-eligible children in Medicaid and help assure that Medicaid-enrolled children receive appropriate services. Care coordination services are further discussed in Sections III.A and IV.E and under SPMs #10-11.

**Infrastructure-building:**

Patient 1st affects the provision of direct services and care coordination services, which are generally enabling services, to Medicaid-enrolled children. The course of Patient 1st and the parallel course of care coordination, therefore, are discussed in Section III.A. To briefly recap, Patient 1st was first implemented in 1988, discontinued in March 2004, and reinstated in early FY 2005. Care coordination services that can be provided under the reinstated program are discussed under "Current Activities."

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate enrollment of Medicaid-eligible children in Medicaid (see National Performance Measure [NPM] #13.		X	X	X
2. Provide services to Medicaid-enrolled children coming to CHDs for care.	X			
3. Under agreement with local physicians participating in the Patient 1st Program, provide EPSDT screening services in some CHDs.	X			X
4. Under subcontract, provide visits in some counties to infants and postpartum patients by social workers and nurses.	X	X		X
5. Provide school health services in some counties.	X			X

6. Administer the Healthy Child Care Alabama Program.		X		X
7. To assist in the removal of barriers to care, have Social Work and Nurse Care Coordinators in every CHD.		X		X
8. Through these care coordinators, provide care coordination services to Medicaid-enrolled children who need the service.		X		
9. Whenever indicated, utilize care coordinators to follow children with elevated levels of lead, infants who fail their newborn hearing screenings, and infants identified as having metabolic disorders.		X		X
10. Periodically provide the Pediatric Physical Assessment Course, to certify CHD non-baccalaureate nursing staff to perform EPSDT screenings.				X

#### b. Current Activities

CHDs continue providing child health services as the opportunity and need arises. Updates on other services, all pertaining to FY 2005, follow.

##### Direct:

Under the reinstated Patient 1st Program, CHDs have agreements with local physicians to provide EPSDT screening services. Such agreements are in place in 18 counties.

Subcontracts are in place in 15 counties to provide home visits to infants and postpartum patients by social workers and nurses.

Public Health Nurses from 7 counties in different public health areas are providing a range of school-based services.

##### Enabling:

In 40 counties, Healthy Child Care Alabama Program staff members continue to work with childcare providers, children 0-5 years of age who receive out-of-home childcare, and the families of these children.

After having been discontinued in March 2004, Medicaid's Patient 1st PCCM was incrementally reinstated beginning in December 2004, and fully reinstated in February 2005. Under the reinstated Patient 1st Program, ADPH care coordinators can receive referrals from a variety of sources, rather than through patients' primary medical providers only. Of particular importance is the ability of ADPH care coordinators to receive referrals and to follow children with elevated levels of lead, infants who fail their newborn hearing screenings, and infants identified as having metabolic disorders, without having a referral from the child's primary medical provider. Because care coordinators can now receive these referrals, FHS's Children's Health Branch staff (who administer the Lead, Newborn Screening, and Newborn Hearing Screening programs), CHD staff providing direct services to children, CHD care coordinators, and FHS's social work staff can now partner to ensure that many children, including Medicaid-enrolled children, receive needed health care services.

##### Infrastructure-building:

A Pediatric Physical Assessment Course, discussed in Section III.B, was developed by ADPH and provided to 15 public health nurses in November 2004. The purpose of the training was to certify non-baccalaureate nursing staff to perform EPSDT screenings. The 2-day course was taped for future training needs.

#### c. Plan for the Coming Year

FY 2005 activities will basically continue in FY 2006, subject to need and feasibility. These include:



- 1) Direct--provision of child health services by CHDs, provision of home visits to infants and postpartum patients under subcontract, and provision of school health services in some counties.
- 2) Enabling--operation of the Healthy Child Care Alabama Program, and provision of care coordination.
- 3) Infrastructure-building--Internal (within ADPH) and external (with other entities) collaboration regarding how to best promote children's access to health care.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.9	2	2	2	2
Annual Indicator	2.0	2.0	2.1	2.0	2.1
Numerator	1282	1188	1227	1216	1230
Denominator	63166	60294	58867	59356	59117
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	2	2	2	2	2

#### Notes - 2002

The reported prevalence of very low birth weight (VLBW) generally continues to increase slightly or remain stable. For example, the reported live-birth prevalence of VLBW was 2.01% in 1999-2001, versus 1.94% in 1996-98. Further, per preliminary numbers, the prevalence increased to 2.1% in 2002 (versus 2.0% in 2001). Targets, therefore, continue to remain at 2.0%.

See note to Calendar Year 2004 for a discussion of related issues, including reporting issues.

#### Notes - 2003

The reported prevalence of very low birth weight (VLBW) generally continues to increase slightly or remain stable. For example, the reported live-birth prevalence of VLBW was 2.03% in 2000-2002, versus 1.97% in 1997-99. Per preliminary numbers, the prevalence decreased slightly to 2.05% in 2003 (versus 2.08% in 2002). Targets continue to remain at 2.0%.

See note to Calendar Year 2004 for a discussion of related issues, including data issues.

#### Notes - 2004

As has been the case for several years, the reported prevalence of very low birth weight (VLBW) generally continues to increase slightly or remain stable. For individual years from

2000-2004, this indicator has ranged between 2.0% and 2.1%. For this reason, we have retained the objective of 2.0% in recent years, and plan to retain this objective for the foreseeable future unless the prevalence of VLBW notably changes.

Data issues: The degree to which this indicator's increase or, at best, failure to decline reflects an actual increase versus variations over time in reporting cannot be assessed from vital statistics data alone. Researchers in Alabama have previously reported their perception that reporting of under 500 gram births, for which "the dividing lines between live birth, stillbirth, and spontaneous mid-trimester abortion are...often difficult to determine," had certainly increased (reference #5, in Appendix C). Conceivably, this perceived increase in reporting of extremely low birth weight infants had actually occurred and may have continued.

Several hypothetical explanations for the reported continued increase in VLBW merit consideration and data-based assessment. First, trends in multiple births, which are discussed in the State's Fiscal Year (FY) 2004-05 Maternal and Child Health Needs Assessment report, affect trends in VLBW. Second, the reporting issues described above merit consideration. Third, the possibility that advances in prenatal and perinatal care have resulted in live births of some VLBW babies who would have died before birth in the absence of such care should be considered. Finally, the possibility of unfavorable trends, or at least failure to decline, in risk markers for women giving birth should be explored. Trends in certain risk markers are also discussed in the State's FYs 04-05 MCH Needs Assessment report.

#### a. Last Year's Accomplishments

FHS's overall strategy for addressing very low birthweight (VLBW) has been to maintain and develop the infrastructure for regionalized health care; seek to ascertain what interventions are most likely to reduce the frequency of VLBW, and develop strategies based on information so gathered.

##### Direct:

CHDs provided family planning services with priority to low-income clients and, per contract with some Medicaid Primary Contractors, prenatal care in 10 counties and care coordination in 24 counties.

##### Enabling:

WIC continued providing food vouchers and nutritional counseling to eligible pregnant women.

Use of the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) model in ADPH clinics continued.

Family Planning clients were educated about the importance of prenatal care, folic acid supplementation, etc. Counseling on the need for family planning was provided, through contract, by a Huntsville, Alabama, hospital's staff to mothers with infants in neonatal intensive care units.

##### Population-based:

Initiatives regarding adolescent pregnancy are discussed under NPM #8.

##### Infrastructure-building:

With respect to background, by August 2002, 5 Regional Nurse Perinatal Coordinator (RNPC) positions were created and filled with nurses (1 in each perinatal region). The RNPCs acted as executive directors for the RPACs, to help the RPACs address regional perinatal issues, and served as liaisons between SPAC and the RPACs. Activities of the RNPCs included recruiting RPAC members and completing annual needs assessments for their respective regions. Reducing the prevalence of VLBW was identified as a priority for each RPAC. In FY 2003 the RNPCs worked with the RPACs to revitalize the State's system of regionalized perinatal care,

perform regional needs assessment, and develop a regional plan to address VLBW.

RNPCs continued their activities in FY 2004. The SPP used its FY 2003 regional perinatal needs assessments to develop strategies for FY 2004. Based on these strategies, activities were implemented in FY 2004 to promote smoking cessation, reduce the prevalence of unintended pregnancy, and reduce the prevalence of short inter-pregnancy interval.

SPP continued partnering with SPAC, which continued meeting quarterly. SPP also continued partnering with AMOD on AMOD's campaign to raise awareness about preterm birth. As discussed in Section III.E, FHS staff attended a press conference convened by AMOD and 3 other organizations, to support their call for full funding of Medicaid. Further, SPP and AMOD staff attended annual meetings of the Alabama Section of ACOG, the Alabama Chapter of AAP, and the Alabama Academy of Family Physicians to encourage support of AMOD's efforts. AMOD provided educational materials and supplies for the RNPCs to conduct quarterly meetings for maternal-infant nurse managers. These meetings provided continuing education and the means for networking among perinatal providers in each region, in order to strengthen regionalization of perinatal care.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer family planning services to CHD clients, including teens, needing the services.	X			
2. Educate CHD family planning clients about the importance of prenatal care.		X		
3. Implement initiatives to reduce the occurrence of adolescent pregnancy. (See NPM #8.)	X	X	X	X
4. Work with the State Perinatal Advisory Council (SPAC) and Regional Perinatal Advisory Councils (RPACs) to maintain and strengthen the State's regionalized system of perinatal care and perform periodic regional needs assessments.				X
5. In collaboration with the Alabama Chapter of the March of Dimes and the State and Regional Perinatal Advisory Councils, seek to identify and implement strategies to reduce the occurrence of very low birthweight.			X	X
6. As part of the above effort, seek to raise awareness about preterm birth and its consequences.			X	X
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Cross-cutting:

Unless previously stated otherwise, FY 2004 activities basically continue in FY 2005.

##### Infrastructure-building:

Medicaid is bidding their Maternity Care Program, and ADPH is working toward discontinuing provision of prenatal care services by June 2005.

FHS staff are serving on USA's State Fetal Alcohol Syndrome Disorders Task Force. This task force is a result of a 1-year planning grant to develop a State plan to address fetal alcohol syndrome. The state plan may ultimately include an initiative to help prevent fetal alcohol syndrome disorders through the existing CHD family planning system, if funds become available for this purpose.

### c. Plan for the Coming Year

Cross-cutting:

Unless previously stated timeframes indicate otherwise, FY 2004 activities will basically continue throughout FY 2006.

If approved by Medicaid as part of the Family Planning Medicaid Waiver, Plan First, multivitamins with folic acid will be provided to all family planning clients. If funds become available, an initiative to help prevent fetal alcohol syndrome disorders through the existing CHD family planning system will be implemented. The contract with the Huntsville hospital for family planning referrals will continue.

Objectives of SPP for FY 2006 are to conduct activities designed to:

- 1) Reduce the number of pregnancies leading to birth intervals of less than 2 years.
- 2) Decrease the percent of women who smoke during pregnancy.
- 3) Reduce pregnancies among females 17 years old and younger.
- 4) Implement public awareness activities regarding the importance of preconceptional health.

Planned FY 2006 activities at the regional level, for the State's 5 perinatal regions are to:

- 1) Continue providing information on Plan First and other family planning services.
- 2) Implement smoking cessation intervention training for 20 delivering-physicians clinics in each region. All of these clinics will be in the private sector.
- 3) Provide training to school nurses on an abstinence-based approach to prevention of adolescent pregnancy.
- 4) Implement public awareness and education activities regarding the impact of preconceptional health status on the outcomes of pregnancy. Topics to be addressed include folic acid supplements, hypertension, diabetes, obesity, smoking cessation, and breastfeeding.
- 5) Continue quarterly meetings of SPAC, and continue the service of RNPCs as liaisons between SPAC and RPACs.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	8.5	8.3	8.2	8.1	8.1
Annual Indicator	7.1	8.0	7.0	5.4	8.7
Numerator	23	26	23	18	29
Denominator	324580	326633	328686	330739	332792
Is the Data Provisional or Final?				Final	Provisional
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	8.5	8.3	8.1	7.9	7.7

#### Notes - 2002

The denominator for 2002, 2001 and years prior to 2000 represent the population projection for youths aged 15-19 years in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research. The denominator for 2000 was derived from the 2000 Census of Population, SF 1 File, conducted by the Bureau of the Census, and was the population count for youths aged 15-19 years in the specified calendar year.

International Classification of Diseases, Tenth Revision (ICD-10) codes were used for 1999 through 2002, while International Classification of Diseases, Ninth Revision (ICD-9) codes were used for earlier years. Thus, estimates for 1999 through 2002 may not be comparable to those for previous years.

Although the 1-year rates for 2000 and 2001 are notably below (i.e., better than) the targets for those years, single-year rates for this indicator are very unstable. Therefore, a more appropriate comparison is of the most recent 3-year rate to an appropriate target. The rate of 8.7 deaths per 100,000 youth in this age group in 1999-2001 falls short of reaching the 2000 and 2001 targets. (The rate for CY 2002 is unavailable as of this writing.) Each of the added targets, for 2006 and 2007, is 1.0% below the target for the preceding year. Targets for earlier years are retained from the 2001/2003 MCH Block Grant.

#### Notes - 2003

The denominator for 2003, 2002, 2001 and years prior to 2000 represent the population projection for youths aged 15-19 years in the specified calendar year. These projections are made by Alabama's Center for Business and Economic Research. The denominator for 2000 was derived from the 2000 Census of Population, SF 1 File, conducted by the Bureau of the Census, and was the population count for youths aged 15-19 years in the specified calendar year.

International Classification of Diseases, Tenth Revision (ICD-10) codes were used for 1999 through 2003, while International Classification of Diseases, Ninth Revision (ICD-9) codes were used for earlier years. Thus, estimates for 1999 through 2003 may not be comparable to those for previous years. The estimate for 2003 is rough and very provisional, and additional deaths may yet be reported.

Although the 1-year rates for 2000, 2001 and 2002 are notably below (i.e., better than) the targets for those years, single-year rates for this indicator are very unstable. Therefore, a more appropriate comparison is of the most recent 3-year rate to an appropriate target. The rate of 7.3 deaths per 100,000 youth in this age group in 2000-2002 surpasses (is better than) the

2000, 2001 and 2002 targets.

#### **Notes - 2004**

Please see year 2002 or 2003 notes above for additional comments that are applicable to the denominator for 2004.

ICD-10 codes were used for 2004.

Comparing 2003-04 to 2000-01, this indicator declined by an average of 2.0% per year. Objectives for 2005 onward require an average decline of 2.5% per year, from the 1994 baseline. Because of the higher baseline in 2004, these objectives are higher (that is, less aggressive than) targets for earlier years, which are from previous Maternal and Child Health Services Block Grant Reports/Applications.

#### **a. Last Year's Accomplishments**

##### **Backdrop:**

ADPH's efforts to prevent suicide have been mainly carried out through the Alabama State Suicide Prevention Task Force (Suicide Prevention Task Force) and ACDRS, both of which are discussed below. The Social Work Unit in the Department's Office of Professional and Support Services assumes the lead for ADPH's involvement with the Suicide Prevention Task Force. ACDRS is administered through FHS's Children's Health Branch. The Suicide Prevention Task Force, which first met in March 2002, is concerned with suicide regardless of age. In FY 2003 the task force developed a website, hosted by ADPH and MHMR, providing information about suicide and pertinent available resources.

In FY 2003 ACDRS created the Infant and Child Death Investigation Task Force, in accordance with the mandating legislation's (discussed in Section III.B) charge to develop a standardized infant/child death investigation curriculum for investigators. For several years ACDRS has maintained a website providing information about causes of death in children and youth.

##### **Cross-cutting (Population-based and Infrastructure-building):**

The Suicide Prevention Task Force, ACDRS, and the Infant and Child Death Investigation Task Force continued in FY 2004. Specific activities, all occurring in FY 2004 unless otherwise stated, follow. The ACDRS Director joined the Suicide Prevention Task Force in June 2004.

The Suicide Prevention Task Force continued to meet quarterly in FY 2004, when they completed and published the Alabama State Suicide Prevention Plan. The plan was distributed at a public awareness day on September 8, 2004 in Montgomery, Alabama. The Governor sanctioned the day; and participants who attended included the State Health Officer of Public Health, the Commissioner of Mental Health, survivors of suicide, professionals in the news media, members of the faith-based community, and members of the Suicide Prevention Task Force. A media campaign was launched statewide to publish the toll-free number for suicide-related crisis calls.

The Infant and Child Death Investigation Task Force developed a training course for all infant and child death investigators, which helps standardize and improve death investigation techniques for deaths of infants and children. The course, which is to be taught at all Alabama Police Academies, commenced as in-service training for all experienced investigators in July and August 2004. ACDRS's 3rd set of recommendations to the Governor, made in FY 2004, included an emphasis on the need for death investigators to participate in this course.

The aforesaid websites providing information on, respectively, deaths of children/youth and suicide prevention, continued.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer ACDRS to review unexpected deaths, including suicide, of Alabama children and youth.			X	X
2. With the Alabama Department of Mental Health and Mental Retardation, attend quarterly meetings of the Alabama Suicide Prevention Task Force.			X	X
3. Through the Infant and Child Death Task Force formed by ACDRS, provide curriculum for a training course for child death investigators, to be taught at Alabama police academies.				X
4. Participate in public awareness efforts concerning suicide prevention, including avenues through which those who have attempted suicide, are contemplating suicide, or have been affected by the actual or attempted suicide of others can get help.			X	X
5. Maintain a website providing information on resources that are available for the purpose of preventing suicide and helping those who have been affected by suicide.			X	
6. Maintain a website about causes of death in children and youth.			X	
7. Distribute the "Prevent Youth Suicide" brochure, developed by ACDRS in consultation with the Suicide Prevention Task Force.			X	
8.				
9.				
10.				

**b. Current Activities**

Cross-cutting:

The Suicide Prevention Task Force, ACDRS, and the Infant and Child Death Review Task Force continue functioning.

The Suicide Prevention Task Force is planning another Public Awareness Day for September 2005. The purpose of these days is to raise awareness concerning suicide and potential ways to prevent it: including information about avenues through which those who have attempted suicide, are contemplating suicide, or have been affected by the actual or attempted suicide by others can get help.

In cooperation and consultation with the Suicide Prevention Task Force, in FY 2005 ACDRS developed a "Prevent Youth Suicide" educational brochure, which will soon be published. This brochure identifies warning signs, offers steps for preventing suicide among youth, and suggests specific steps individuals may take to assist troubled youth. The brochure will be distributed throughout the State.

**c. Plan for the Coming Year**

Cross-cutting:

The Suicide Prevention Task Force, ACDRS, and the Infant and Child Death Review Task Force will continue functioning. The Suicide Prevention Task Force and ACDRS will continue maintaining their respective websites.

The Suicide Prevention Task Force is discussing the possibility of sponsoring a Suicide

Prevention Conference for professionals throughout the State. A nationally known speaker and expert would conduct the conference.

In FY 2006 the "Prevent Youth Suicide" educational brochure will be produced in Spanish for statewide distribution.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	79.6	82.9	84.6	86.4	88.2
Annual Indicator	79.2	80.6	83.4	79.4	78.6
Numerator	1015	957	1023	965	967
Denominator	1282	1188	1227	1216	1230
Is the Data Provisional or Final?				Final	Provisional
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	79.8	80.6	81.4	82.2	83

#### **Notes - 2002**

The targets added for 2006 and 2007 are 90%, the same as that for 2005. In FY 2004 targets for 2005 and onward may be revised, to proceed from a 3-year baseline, 2000-02.

#### **Notes - 2003**

The targets added for 2006-2008 are 90%, the same as that for 2005. During the FY 2004-05 needs assessment, objectives for 2005 and onward will be revised.

#### **Notes - 2004**

Comparing 2003-04 to 2000-01, this indicator declined (worsened) by an average of 0.4% per year (based on a multiplicative model). Objectives from 2005 onward require an average annual increase of 1.0% per year, from the percentage for 2003-04 combined. Because of the lower baseline in 2004 and the failure to improve per the preceding comparison, objectives for 2005 onward are lower than those for 2001-2004. Considering the failure of this indicator to improve from 2000-01 to 2003-04, however, the future objectives are somewhat aggressive. The peak during the surveillance period, of 83.4 percent in 2002, was atypical and is not an appropriate referent for setting future objectives.

#### **a. Last Year's Accomplishments**

Data issues:

The reported numbers pertain to live-born infants delivered at perinatal center, defined as any



teaching or non-teaching hospital with 1 or more full-time neonatologists, a neonatal intensive care unit, and 2 or more obstetricians.

**Infrastructure-building:**

Historical background regarding the creation of 5 RNPC positions in FY 2002, and the subsequent role and activities of the nurses filling these positions, is discussed under NPM #15. As stated there, since FY 2002 the RNPCs have worked with the RPACs to revitalize the State's system of regionalized perinatal care. One of the purposes of this system of care is to assure that VLBW infants are born in perinatal centers that can provide appropriate care to these infants. Throughout FY 2004, the RNPCs continued to promote a strong system of regionalized perinatal care.

In FY 2004, in consultation with the Epi/Data Branch, each of the 5 RNPCs began conducting an infant mortality review for her assigned region. The role of the Epi/Data Branch was to help plan the study design and to randomly select deaths to be reviewed. Each RNPC conducted record reviews, and RPAC subcommittees formed the case review teams. The reviews focused on CY 2002 deaths of VLBW infants who were not born at a perinatal center. The review process was the first statewide use of the FIMR model.

The deaths reviewed were divided into two groups, those born at a perinatal center and those born outside a perinatal center. Results of the reviews were identification of issues surrounding the pregnancies, plus recommendations from the case review teams to positively impact such pregnancies and births. All 5 case review teams agreed that few of the deaths of VLBW infants were preventable in terms of medical and hospital care given at delivery or, subsequently, during hospitalization. However, each team identified issues surrounding the pregnancies that could be addressed through community actions or strengthening of the health care system. Salient recommendations regarding VLBW infants pertained to: 1) improvement of risk assessment procedures, 2) provision of preconceptional counseling, 3) improvement of social services referrals, and 4) further strengthening of the system of regionalized perinatal care.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the State Perinatal Program, to promote a strong system of regionalized perinatal care.			X	X
2. Continue quarterly meetings of the State Perinatal Advisory Council.				X
3. Through the Bureau of Family Health Services (FHS's) 5 Regional Nurse Perinatal Coordinators, support SPAC and the 5 Regional Perinatal Advisory Councils.				X
4. Through FHS's Regional Nurse Perinatal Coordinators and Regional Perinatal Advisory Committees, conduct infant mortality reviews.				X
5. Through Community Action Teams in each perinatal region, identify initiatives to address recommendations arising from the completed review of FY 2002 deaths of very low birthweight infants.				X
6. Monitor NPM #17 for each perinatal region, as well as for the State as a whole.				X
7.				
8.				
9.				

10.

### b. Current Activities

In FY 2005 the RNPCs are collaborating with local health councils in each perinatal region. These councils will assume the role of Community Action Teams to identify community initiatives that will address recommendations from the infant mortality case review teams, discussed under "Last Year's Accomplishments." Criteria for selecting additional infant deaths to be reviewed are currently under discussion.

By the end of FY 2005 FHS's Epi/Data Branch will produce maternal and infant profiles, which include the percentage of VLBW live births occurring at perinatal centers, for the State and for each perinatal region.

### c. Plan for the Coming Year

With the support of SPAC and SPP, the RPACs will continue seeking to maintain and strengthen the State's system of regionalized perinatal care. Quarterly meetings of SPAC will continue, and the Regional Perinatal Coordinators will continue liaising between SPAC and the RPACs to implement initiatives developed by SPAC. The 5 RNPCs will continue conducting regional infant death reviews, though these reviews may not focus on VLBW infants. Contingent on having sufficient staff, the Epi/Data Branch will produce maternal and infant profiles for the State and each perinatal region on an annual basis.

**Performance Measure 18:** *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	86.6	85.2	86.4	87.6	86.7
Annual Indicator	82.5	82.1	83.0	83.6	83.7
Numerator	52127	49526	48885	49635	49456
Denominator	63166	60294	58870	59356	59117
Is the Data Provisional or Final?				Final	Provisional
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	87.8	88.9	90	90	90

### Notes - 2002

The numerator is the number reporting prenatal care as beginning during the first, second, or third month, based on the birth certificate item: "Month of Pregnancy Prenatal Care Began—First, Second, etc."

Targets for 2004 and 2005 have been revised, and those for 2006 and 2007 set, to accommodate the slowed rate of improvement in this indicator in recent years. Due to this slowed rate of improvement, in 1999-2001, only 82.5% of live-born infants were from pregnancies in which the mother had received prenatal care during the first trimester of the referent pregnancy. Considering this 3-year prevalence to be the baseline for 2000, the revised and new targets require an annual improvement of 1.2% (multiplicative model). Though appearing modest, these targets are rather aggressive, given the lack of consistent improvement in this indicator from 1998 through 2001 (the latest year for which an estimate is available at this writing).

### **Notes - 2003**

The numerator is the number reporting prenatal care as beginning during the first, second, or third month, based on the birth certificate item: "Month of Pregnancy Prenatal Care Began—First, Second, etc."

By FY 2003 targets for 2004 and 2005 were revised, and those for 2006 and 2007 set, to accommodate the slowed rate of improvement in this indicator in recent years. Due to this slowed rate of improvement, in 1999-2001, only 82.5% of live-born infants were from pregnancies in which the mother had received prenatal care during the first trimester of the referent pregnancy. Considering this 3-year prevalence to be the baseline for 2000, the revised and new targets through 2007 require an annual improvement of 1.24% (multiplicative model). Though appearing modest, these targets are rather aggressive, given the lack of consistent improvement in this indicator from 1998 through 2003.

The target for 2007 has been retained for 2008. Targets for 2005-2008 will be reconsidered, and a target for 2009 set, during the FY 2004-05 maternal and child health needs assessment.

#### **a. Last Year's Accomplishments**

FY 2004 activities designed to promote early entry into prenatal care included the following.

##### **Direct:**

See Form 7 for the number of pregnant women receiving Title-V-funded services in CHDs in FY 2004. (This number is currently unavailable to the writer.) As stated under NPM #15, under contract with some Medicaid Primary Contractors, CHDs provided prenatal care in 10 counties. On April 30, 2004, JCDH, which had 1 of the larger CHD maternity programs, discontinued providing maternity care coordination and prenatal care.

##### **Enabling:**

All CHD family planning clients were provided information about the importance of early and continuous prenatal care. As stated under NPM #15, via contract with some Medicaid Primary Contractors, CHDs provided maternity care coordination in 24 counties. With JCDH no longer providing maternity care coordination after April 2004, several PHAs were providing the bulk of CHD maternity care services: PHA 1 in northeast Alabama, PHA 8 in south-central Alabama, PHA 10 in southeast Alabama, and PHA 11 in southwest Alabama. Mobile County, which comprises PHA 11 and is the State's 2nd most populated county, continued providing both prenatal care and care coordination services.

##### **Population-based:**

The Bureau continued operation of a toll-free hotline that helps pregnant women access providers and provides educational materials about pregnancy.

##### **Infrastructure-building:**

The Medicaid Maternity Care Program continued statewide; this system addressed the issues of early entry into care, compliance with care, referral patterns, and delivery services. However, ADPH's Uncompensated Maternity Care Project was discontinued early in FY 2004 due to funding reductions discussed in Section III.B.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate CHD family planning clients on the importance of early and continuous prenatal care.		X		
2. Operate a toll-free hotline that helps pregnant women access providers and educational materials.			X	
3. Collaborate with SCHIP staff to explore the feasibility of expanding Alabama SCHIP to include the unborn child, in order to provide prenatal, delivery, and postpartum services for uninsured women whose children would be SCHIP-eligible.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Cross-cutting:

Unless indicated otherwise below or in previously stated time frames, FY 2004 activities basically continue in FY 2005.

As discussed in Section III.A, by March 2005 it was determined that the private sector had both the desire and capacity to provide all the prenatal care required under the SOBRA Medicaid program. For this reason and because of financial and liability-related issues, ADPH decided to completely withdraw from providing prenatal care. Most CHDs made a parallel decision to no longer provide care coordination for pregnant patients. Though a few CHDs may continue to work with private providers in the provision of care coordination services, care coordination of pregnant women is now provided mainly through the private sector. Medicaid is currently bidding their Maternity Care Program for the new project period beginning June 1, 2005.

Access to adequate prenatal care may be determined by the availability of health insurance coverage for the pregnant mother. Most of the deliveries reported as being "self pay" on the State's live birth certificate presumably involve mothers who have no health insurance coverage for prenatal care and do not qualify for Medicaid. Infants of these mothers have typically had the highest infant mortality rate, compared to infants of Medicaid-enrolled or privately insured mothers. Because no State programs are currently available for uninsured pregnant women, FHS is collaborating with SCHIP to explore the feasibility of expanding SCHIP to include the unborn child. Federal regulation allows for SCHIP coverage of the unborn children of uninsured women who are not eligible for Medicaid--to provide insurance coverage for prenatal, delivery, and postpartum services for mothers whose children would be SCHIP-eligible. The envisioned expansion of SCHIP would include the unborn of non-citizen women. An estimated 2000 Alabama residents would qualify for coverage of prenatal care via expansion of SCHIP to cover the unborn.

**c. Plan for the Coming Year**

Plans for FY 2006 follow.

**Direct/Enabling:**

CHDs will continue providing family planning services, including counseling regarding the importance for early and continuous prenatal care. Only 2 or 3 PHAs are expected to provide, through certain CHDs, care coordination for pregnant women.

Population-based: Operation of a toll-free hotline that informs pregnant women and helps them access providers will continue.

**Infrastructure-building:**

The Medicaid Maternity Care Program will continue.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The degree to which the Bureau of Family Health Services (BFHS) addresses the folic acid intake of women of childbearing age*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	11	10	15	18	13
Annual Indicator	11.0	13.0	13.0	13.0	13.0
Numerator	11	13	13	13	13
Denominator	18	18	18	18	18
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	13				

### Notes - 2002

One of the checklist items for this measure was revised slightly for FY 1999 and subsequent years. That is, "Implement a major media campaign to educate Alabama women of childbearing age about the importance of folic acid intake" has been changed to "Participate in a major media campaign to educate Alabama women of childbearing age about the importance of folic acid intake." The scored checklist is attached to Section IV. D., SPM #01, Last Year's Accomplishments. In FY 2000, the target for 2001 was revised, and those for 2002-2005 set, per the rationale described in Section 4.1.

As discussed under this measure in Section III.D of this FY 2002 Report/FY 2004 Application, the Bureau will probably not conduct a survey regarding knowledge about, consumption of, or biochemical status of folic acid (a checklist criterion for this performance measure) in the foreseeable future. The reason for not conducting such a survey is that other reporting

responsibilities of the Bureau's Epidemiology and Data Management (Epi/Data) Branch are deemed of higher priority than a folic acid survey and preclude dedication of resources to such a survey. Accordingly, targets for 2004-2007 have been revised downward, to 13 on a scale of 0-18. The Epi/Data Branch will, however, seek to ascertain whether information about folic acid consumption in nonpregnant women of childbearing age in Alabama is available from other sources.

#### **Notes - 2003**

One of the checklist items for this measure was revised slightly for FY 1999 and subsequent years. That is, "Implement a major media campaign to educate Alabama women of childbearing age about the importance of folic acid intake" has been changed to "Participate in a major media campaign to educate Alabama women of childbearing age about the importance of folic acid intake." The scored checklist is attached to Section IV. D., SPM #01, "Last Year's Accomplishments." In FY 2000, the target for 2001 was revised, and those for 2002-2005 set, per the rationale described in the Maternal and Child Health Services Block Grant FY 1999 Annual Report/FY 2001 Application.

As discussed under this measure in Section III.D, the Bureau of Family Health Services (Bureau) will probably not conduct a survey regarding knowledge about, consumption of, or biochemical status of folic acid (a checklist criterion for this performance measure) in the foreseeable future. The reason for not conducting such a survey is that other reporting responsibilities of the Bureau's Epidemiology and Data Management (Epi/Data) Branch are deemed of higher priority than a folic acid survey and preclude dedication of resources to such a survey. Accordingly, targets for 2004-2008 have been revised downward, to 13 on a scale of 0-18. The Epi/Data Branch will, however, seek to ascertain whether information about folic acid consumption in nonpregnant women of childbearing age in Alabama is available from other sources.

During the FY 2004-05 maternal and child health needs assessment, the Bureau will determine whether this measure will remain operative.

#### **Notes - 2004**

This measure becomes inoperative in FY 2005, so no objectives are set for FY 2006 onward.

##### **a. Last Year's Accomplishments**

###### **Rationale for measure:**

Addressing folic acid intake of childbearing-aged women can reduce occurrence of serious, lifelong morbidity and prevent a few infant and childhood deaths. The measure concerns the priority need "promote education/outreach."

Unless stated otherwise, the activities below have been occurring for several years, including FY 2004.

###### **Enabling:**

WIC and Family Planning staff continued giving WIC folic acid pamphlets to family planning clients during initial and annual visits.

###### **Infrastructure-building:**

Through SPP, folic acid tablets were supplied to private providers and CHDs who prescribe 4 milligrams of folic acid daily to women who are contemplating pregnancy and are considered to be high at risk of conceiving a child who would have a neural tube defect. This service has been ongoing since December 2001.

FHS continued requiring preconceptional counseling of family planning clinics, according to protocol. The SPP Director, in FY 2002, had developed the protocol regarding preconceptional counseling.

The Alabama Folic Acid Council (AFAC), which had been active for several years, disbanded in FY 2004. This discontinuation of AFAC was due to ADPH's fiscal constraints and the re-direction by AMOD of funds, previously set aside for AFAC, to the March of Dime's campaign to prevent prematurity. A plan, developed in June 2003, for continuing folic-acid-related activities was presented to SPAC in November 2003. Under the plan, which SPAC approved, SPAC became the State's leadership body for continuing folic acid education activities. Also under the plan, each RPAC created a folic acid subcommittee. These subcommittees continued the work of AFAC on a regional level, with emphasis on education of health care providers about the need to address folic acid consumption by women capable of becoming pregnant. SPP staff continued to arrange SPAC meetings and liaise among SPAC and the RPACs. Further, the SPP Director and a member of USA Genetics Center's staff represented Alabama on the National Folic Acid Council.

As had been the case in preceding years, a survey on knowledge about, consumption of, or biochemical status of folic acid (a checklist criterion for this performance measure), was not deemed feasible because of competing data-related priorities. Accordingly, the target for this measure, which was revised downward in FY 2003, remains at 13, where the State's score for this measure has remained since FY 2001.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide folic pamphlets to county health department (CHD) family planning clients.		X		X
2. Designate the State Perinatal Advisory Council as the State's lead for education on preconceptional folic acid consumption.				X
3. Through the 5 Regional Perinatal Advisory Councils, promote health care providers' awareness of the need to address folic acid consumption by women who may become pregnant.				X
4. Coordinate action to provide folic acid tablets to CHDs and to certain private providers of health care.				X
5. Participate in the National Folic Acid Council.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

##### Infrastructure-building:

This SPM becomes inoperative in FY 2005, so will not be reported on in future MCH applications/reports. However, FHS's efforts to promote adequate folic acid consumption by women capable of becoming pregnant continue. Specifically, SPP's RNPCs continue to distribute folic acid educational materials to physicians' clinics. In addition to providing folic acid tablets to private providers and CHDs, FHS is supplying the same prescription dose to the State's 5 regional perinatal referral centers and 2 children's hospitals.

### c. Plan for the Coming Year

#### Infrastructure-building:

As stated under "Current Activities," this measure will have become inoperative in FY 2005, so will not be continued in the next needs assessment cycle. However, FHS will continue requiring preconceptional counseling in ADPH family planning clinics. The RPACs will continue encouraging healthcare providers to educate their female patients of childbearing age about the need for adequate consumption of folic acid. SPP will continue collaborating with other groups to promote folic acid consumption by women who can become pregnant, and coordinating action to provide folic acid tablets to certain providers of health care.

**State Performance Measure 7: *The degree to which key maternal and child health databases are developed and analyzed, with pertinent findings reported to and utilized by the Bureau of Family Health Services (BFHS)***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	15	15	18	18	18
Annual Indicator	9.0	13.0	14.0	16.0	16.0
Numerator	9	13	14	16	16
Denominator	18	18	18	18	18
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	18				

#### Notes - 2002

The scored checklist is attached to Section IV. D., SPM #07, Last Year's Accomplishments.

#### Notes - 2003

The scored checklist is attached to Section IV.D, SPM #02 (using the CURRENT numbering system), "Last Year's Accomplishments."

During the FY 2004-05 maternal and child health needs assessment, the Bureau will determine whether this measure will remain operative. If the measure remains operative, criteria will most likely be revised to reflect current data-related priorities.

#### Notes - 2004

No targets are set for FY 2006 onward because this measure becomes inoperative in 2005. Another measure pertaining to maternal and child health (MCH) data capacity will replace it, and objectives for that measure will be reported in the MCH Block Grant Services 2005 Report/2007 Application.



## a. Last Year's Accomplishments

MCH Populations Served: Pregnant women, mothers, and infants; children; CSHCN

### Rationale for measure:

This indicator concerns ADPH's priority need to promote education/outreach, since data analysis should help identify issues to address through education/outreach. Though not directly related to an outcome measure, this indicator pertains to surveillance and better understanding of risk markers for infant and child morbidity/mortality.

### Backdrop:

Scores for this measure are based on 6 criteria shown in the attached checklist. Each criterion has a maximum possible score of 3, which 4 criteria have attained. The criteria on child death review and on PHA-specific analyses are each scored at 2. Regarding area-specific analyses, the Epi/Data Branch is focusing on analyses according to perinatal region, rather than PHA, since SPP staff use findings for perinatal regions.

For several years 3 FHS units have been especially critical to the Bureau's capacity to develop, analyze, and utilize MCH databases. These are ACDRS, discussed in Section III.A and under NPMs #10 and #16; SPP, discussed in multiple places throughout this report/application; and the Epi/Data Branch, which assumes the lead for MCH Block Grant annual reports/applications and needs assessment. Selected activities of these units are discussed below. Unless stated otherwise, all activities occurred in FY 2004.

### Cross-cutting:

Most ACDRS activities pertain to infrastructure-building and population-based services. In FY 2004 all 41 Judicial Circuits had a Local Child Death Review Team Chairperson, and there were nearly 60 Local Child Death Review Teams in the State. These teams may submit their data collection forms via mail, fax, or online. (The proportion of assigned child death cases for which reviews were completed by local teams has been over 80% in the last 2 reporting years, FYs 2001-2002, up from 64% circa FY 1998.) ACDRS maintained a comprehensive, searchable database that contains all data collected since the inception of the program. ACDRS also maintained a website that allows online submission of data from the Local Child Death Review Teams and provides information on underlying legislation, the child death review process, causes of child death, summary recommendations of the State Child Death Review Team, links to nationwide resources related to child death review, and downloadable/printable versions of all ACDRS publications, including the ACDRS Annual Reports.

### Infrastructure-building:

The SPP Director liaised with 3 local FIMR teams. Under the leadership of SPP, infant death review was conducted on a statewide basis as described under NPM 17. As stated there, each of the 5 RNPCs conducted infant death reviews for her assigned region, and RPAC subcommittees formed the case review teams. Reviews conducted in FY 2004 focused on deaths of VLBW infants.

In FY 2004 the Epi/Data Branch focused on implementation of the 5-year MCH needs assessment.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Alabama Child Death Review System (ACDRS), to			X	X

review unexpected deaths in children and youth.				
2. Through the Bureau of Family Health Services' 5 Regional Perinatal Nurse Coordinators and 5 Regional Perinatal Advisory Councils, conduct infant death reviews.				X
3. Liaison with 3 local fetal and infant mortality review teams.				X
4. Conduct a comprehensive, statewide maternal and child health needs assessment every 5 years, supplemented by ongoing needs assessment as indicated and feasible.				X
5. Periodically produce maternal and infant profiles for the State and each perinatal region.				X
6. Administer the State Systems Development Initiative Project, which currently focuses on electronic linkage of live birth records to certain other databases.				X
7.				
8.				
9.				
10.				

#### b. Current Activities

All the following activities pertain to FY 2005 unless stated otherwise.

Cross-cutting (Population-based and infrastructure-building):  
ACDRS's activities continue.

Infrastructure-building:

Statewide infant death reviews continue as described under NPM #17 and recapped under "Last Year's Accomplishments." Criteria for selecting additional infant deaths to be reviewed are under discussion.

Through mid-July 2005 the Epi/Data Branch's focal activities will be completion of the FY 2004-05 MCH needs assessment report; completion of this MCH 2004 Report/2006 Application; completion of the SSDI report to be submitted by June 15, 2005; and performance of SSDI data-linkage tasks. SSDI is further discussed in Section IV.F. Further, the Epi/Data Branch has drafted, and expects to soon finalize, maternal and infant profiles for the State and each perinatal region. These profiles are included in an appendix to the 5-year MCH needs assessment report, which has been submitted by e-mail, per federal guidance. After mid-July the branch will focus on laying the groundwork for linkage of live birth records to Medicaid records, as described in Section IV.F, and analysis of 2 important databases that could not be analyzed by branch staff during the FY 2004-05 MCH needs assessment. These databases are the 2001 National Survey of Children with Special Health Care Needs and the circa 2003 National Survey of Children's Health.

For several years ADPH, including FHS, administrators seeking to increase the Department's capacity to analyze and utilize data have recognized a major barrier to this endeavor. This barrier is the noncompetitive nature of the State's salary range for epidemiologists and public health research analysts. Accordingly, after consulting with several ADPH stakeholders, including 2 FHS staff members, the Department's Personnel Office approached the State Personnel Office with a proposed higher salary range for the State's 3-level, non-physician epidemiologist classification series. This proposal was approved by the State Personnel Board and signed by the Governor in May 2005. Though the new range may not be competitive with the private sector, it provides slightly more flexibility concerning the beginning salary for an entry-level epidemiologist, which the Department hopes will facilitate recruitment of newly

masters-prepared epidemiologists who would otherwise seek employment elsewhere. Further, it is hoped that the higher salary caps will promote better retention of epidemiologists. State Personnel staff concluded that a more thorough review was needed before a higher salary should be proposed for public health research analysts. As part of this review, State Personnel staff are to contact public health research analysts to ascertain their job duties.

The criteria for this SPM become inoperative in FY 2005, but the SPM will be replaced by another on MCH data capacity. The new SPM may be similarly worded, but the corresponding checklist will be updated.

### c. Plan for the Coming Year

As stated under "Current Activities," criteria for this SPM will have become inoperative in FY 2005, but the SPM will be replaced by another checklist-based measure of MCH data capacity. FHS's commitment to increasing MCH data capacity will surely continue. All the following activities pertain to FY 2006 unless stated otherwise.

Cross-cutting (Population-based and infrastructure-building):  
ACDRS's activities will continue.

Infrastructure-building:

The 3 local FIMR teams will continue receiving assistance from the SPP. RNPCs and RPACs will continue collaborating to conduct infant death reviews.

The Epi/Data Branch will continue performing analyses necessary for meeting MCH Block Grant annual reporting requirements, as well as coordinating the preparation of the MCH annual reports/applications. As well, the branch will continue to administer the SSDI Project, which currently focuses on electronic linkage of live birth records to certain large databases and is discussed in Section IV.F. Ongoing MCH needs assessment will be performed as needed and feasible--both by Epi/Data Branch staff and by SPP staff, whose focus is at the regional level. Additionally, Epi/Data Branch staff hope to develop a Title V webpage that could be accessed from the Department's website. The purpose of this page would be to further disseminate information about the State's Title V Program and to seek input concerning Title V-related needs and services. As mentioned in Section III.B, FHS will seek to add 1.5 epidemiologist FTEs, through contract and/or merit system hiring, to assist the Epi/Data Branch with data-related tasks and reports. If these FTEs become available and more competitive priorities do not arise, the branch will annually produce maternal and infant profiles for the entire State and each of the 5 perinatal regions.

**State Performance Measure 10:** *The degree to which the State assures case management to facilitate access to, as well as full benefit from, available health care for children enrolled in the Patient 1st program*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	10	15	15	15	0

Annual Indicator	12	12	13	13	13
Numerator	12	12	13	13	13
Denominator	15	15	15	15	15
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	0				

#### Notes - 2004

The scored checklist is attached to Section IV.D, "Last Year's Accomplishments."

At the time the Maternal and Child Health Services Block Grant FY 2003 Report/FY 2005 Application was submitted, the Alabama Medicaid Agency's Patient 1st Program, to which this measure pertained, had been terminated and had not yet been reinstated. For that reason, in FY 2004 targets for FY 2004 and forward were reset to 0. This measure becomes inoperative in FY 2005, so there are no targets for FY 2006 onward.

#### a. Last Year's Accomplishments

MCH Population Served: Children

Rationale for measure: This measure pertains to 2 priority needs: to assure dental care and to promote education/outreach. It was chosen because case management helps patients to access medical, social, and educational services and other community resources.

#### Backdrop:

Case management and care coordination are discussed in multiple places in this document: Sections III.A, III.E, and IV.B; under NPMs #1, #8, #12, #14, and #18; and under SPM #11. The following discussion recaps some of the information provided elsewhere and provides additional information as well. In this report the terms "case management" and "care coordination" pertain to the same service--though some programs use 1 term and some the other.

Since January 1999 the MAR Case Management Program had been the primary means of providing case management to children enrolled in Patient 1st, Medicaid's PCCM. Under the MAR Program, ADPH staff could provide case management only if the client had been referred by the primary provider or dentist. Under Patient 1st, ADPH's provision of case management services to Medicaid-enrolled children had expanded rapidly and, by early FY2004, about 16 FTEs were devoted to providing case management services under the MAR Program. All the following activities or developments pertain to FY 2004 unless otherwise stated.

The 5 criteria on which this measure is scored are attached. Four of the criteria are assigned the maximum score for a single criterion, which is 3. The score for the criterion concerning identification of outcome measures and implementation of an evaluation plan for case management remains at 1, i.e., partially met.

#### Cross-cutting (Enabling, Infrastructure-building):

As discussed in Section III.A, the discontinuation of Patient 1st on March 1, 2004 led to the concurrent discontinuation of MAR Case Management. However, through an agreement with Medicaid, ADPH continued to provide care coordination to children and adolescents (through 20 years of age) under EPSDT guidelines. Under EPSDT Care Coordination, children and youth through 20 years of age who had full Medicaid coverage could receive care coordination

at CHDs. EPSDT Care Coordination is further discussed under SPM #11.

In FY 2004 ADPH's central office staff provided quarterly certification training to 45 MAR case managers and 166 EPSDT care coordinators. Further, before implementation of the EPSDT Care Coordination Program, FHS's Social Work Consultant and Training Coordinator presented information on the program via satellite to a statewide audience.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Administer the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Care Coordination Program.				X
2. Provide care coordination to EPSDT-eligible children and youth who are seen at CHDs and need the service.		X		
3. Through care coordination, help eligible children access needed medical, social, and educational services.		X		
4. Through collaboration among Alabama Department of Public Health staff, assure that children identified at birth as having or potentially having hematologic disorders, metabolic disorders, or impaired hearing receive the necessary follow up.				X
5. Provide quarterly training events for Alabama Department of Public Health care coordinators.				X
6. Explore the feasibility of piloting, in collaboration with SCHIP, a case management program for SCHIP-enrolled children who have asthma and who frequently have emergency room visits or hospitalizations.				X
7.				
8.				
9.				
10.				

#### b. Current Activities

This SPM becomes inoperative in FY 2005, but FHS's emphasis on care coordination will continue.

##### Enabling:

FHS's Children's Health Branch staff have worked very closely with persons providing EPSDT Care Coordination. This collaboration has involved referring for care coordination children who have elevated lead levels or who fail newborn hearing screenings. Children's Health staff plan to expand this collaboration by making more referrals for metabolic disorders identified at birth. Staff from both the Lead and Newborn Hearing Programs are presenters at the Patient 1st Care Coordination Certification Training that is held quarterly at ADPH's central office.

##### Infrastructure-building:

A redesigned Patient 1st Program was incrementally implemented beginning in December 2004, and fully implemented by February 2005. Under the redesigned program patients are again assigned to a primary care provider, so have a medical home. However, care coordination can still be provided for EPSDT-eligible children and Medicaid-eligible adults without a referral from the patient's primary medical provider. As anticipated, the caseload for ADPH care coordinators continues to increase statewide, so additional staff have been hired.

JCDH has placed a nurse and a social work care coordinator in each of their clinics and are now providing care coordination under Patient 1st, which they had not been doing in FY 2004. Though JCDH's service appears to be limited mainly to referrals received from within their physician-staffed clinics, some referrals concerning dental needs are being taken from private providers. With JCDH's implementation of care coordination under Patient 1st, all of the State's CHDs now provide care coordination for Patient 1st enrollees.

As was true for the MAR Program, staff providing care coordination under the EPSDT guidelines or any other care coordination program are licensed social workers and baccalaureate-prepared nurses employed by ADPH. All new Patient 1st care coordinators are required to attend a 3-day certification training prior to working as care coordinators under the Patient 1st Program.

Protocol manuals for all care coordination programs are now available on ADPH's Lotus Notes Document Library. Except for JCDH, all care coordinators are assigned computers and have access to Lotus. JCDH has its own electronic system and is unable to access the ADPH system. Copies of all pertinent documents are sent to the Social Work Coordinator in JCDH, to be dispersed to workers.

FHS's Social Work Consultant and SCHIP staff are having discussions regarding case management of children who have asthma and diabetes and who also have high utilization of health care services (emergency room visits, hospitalizations, etc.). The possibility of conducting a pilot, in 1 or more sites, to focus on children with asthma is being considered.

#### c. Plan for the Coming Year

Cross-cutting (Enabling, Infrastructure-building):

As stated under "Current Activities," SPM #10 will have become inoperative in FY 2005, so will not be continued in the next needs assessment cycle. ADPH will continue its commitment to facilitating access to care coordination for all Patient 1st enrollees who need it, however. As a corollary, the SPM pertaining to the percent of Patient 1st-enrolled children who receive care coordination (SPM #11) will continue. ADPH will therefore continue and/or expand upon most of the FY 2004-05 activities. These include:

- 1) Collaboration between FHS's Children's Health Branch and Social Work Program.
- 2) Provision by ADPH of care coordination to EPSDT-eligible children under the age of 21 years in the Patient 1st Program.
- 3) Provision by ADPH's central office staff of certification training for ADPH workers who provide care coordination to EPSDT-eligible children in the Patient 1st Program.
- 4) Maintenance of protocol manuals concerning care coordination.

As well, in FY 2006 FHS will continue working toward provision of case management for SCHIP enrollees with asthma and diabetes, and increasing the number of care coordinators and managers in the counties. Additionally, FHS will continue working toward implementation of a Centralized Referral System for care coordination, and improving quality assurance by tracking referrals through this system. A new social work position has been created in FHS to develop and monitor the Centralized Referral System and to work with SCHIP on the asthma project. Due to space constraints, the Centralized Referral System has not been discussed under "Last Year's Accomplishments" or "Current Activities," but is discussed in Section IV.E.

*Patient 1st Program who received case management services during the reporting year.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	2	3	4	0
Annual Indicator	0.8	2.7	2.4	4.1	4.9
Numerator	1684	6091	5540	9127	13824
Denominator	210497	226196	233994	222416	279301
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	0	0	0	0	

**Notes - 2002**

Because this program provides very little case management for older children and adults, the program director estimates that about 95% of the program participants are aged 0-9 years. Thus a factor of 0.95 was applied to the 5,832 persons receiving services during FY 2002, yielding an estimate of 5,540 children 0-9 years who were enrolled in Patient 1st and received case management services from the Alabama Department of Public Health during the reporting period.

Added objectives for 2006 and 2007 require an absolute increase of 1% each year, but will be revised downward if we remain below target in FYs 2003 and 2004.

**Notes - 2003**

Because this program provides very little case management for older children and adults, the program director estimates that about 95% of the program participants are aged 0-9 years. Thus a factor of 0.95 was applied to the 5,832 persons receiving services during FY 2002, yielding an estimate of 5,540 children 0-9 years who were enrolled in Patient 1st and received case management services from the Alabama Department of Public Health (Department) during the reporting period. Similarly, a factor of .95 was applied to the 9,607 persons receiving services during FY 2003, yielding an estimate that 9,127 children 0-9 years of age were enrolled in Patient 1st and received case management services from the Department during the reporting period.

As discussed in Section IV.D, the Alabama Medicaid Agency discontinued the Patient 1st Program, effective March 1, 2004. Consequently, objectives for FY 2004 and onward have been downgraded to 0. As a corollary, this measure will be changed to "inactive" status in the Maternal and Child Health Services Block Grant FY 2004 Annual Report/FY 2006 Application.

**Notes - 2004**

Because this program provides very little case management for older children and adults, the program director estimates that about 95% of the program participants are aged 0-9 years. Thus a factor of 0.95 was applied to the 14,552 persons receiving services during FY 2004, yielding an estimate of 13,824 children 0-9 years who were enrolled in Patient 1st and received

case management services from the Alabama Department of Public Health during the reporting period.

**a. Last Year's Accomplishments**

Rationale for measure: See SPM #10.

**Backdrop:**

Care coordination and case management are extensively discussed in Section III.A and under SPM #10, and to some degree in Section IV.E. All the activities discussed under SPM #10 promote progress concerning SPM #11 as well. The following discussion focuses on issues that concern care coordination of 0-9 year-old children and are not discussed elsewhere. All activities occurred in FY 2004 unless stated otherwise.

**Crosscutting (Enabling, Infrastructure-building):**

When EPSDT Care Coordination was first implemented patients were no longer assigned by Medicaid to a primary medical provider so could access care coordination without being referred by a doctor or a dentist. Care coordinators could therefore receive referrals from all sources, removing a major barrier to ensuring that children can access needed medical and dental services. After initiation of the EPSDT Care Coordination Program on March 1, about 28 FTEs were dedicated to care coordination in the rest of FY 2004 (up from 16 FTEs under the MAR Program). This growth in FTEs was due to the increased caseload following discontinuation of the requirement for the primary medical provider's referral. In FY 2004 EPSDT Care Coordination became available in all the State's counties. Referrals could be made by calling CHDs and requesting coordination for medical and dental care.

Care coordinators used a 1-page needs assessment to identify patients who were routinely seen in CHDs for WIC services, immunizations, etc. and who may have had unmet needs. If needs were identified during the assessment, patients were offered care coordination. Because provision of EPSDT Care Coordination did not require referral from the primary medical provider, Medicaid reimbursed for care coordination for infants who had been referred by hospitals for that purpose. Prior to the initiation of EPSDT Care Coordination, securing reimbursement for care coordination of these infants had been problematic.

As they had in preceding years, dentists referred children to ADPH for care coordination. Accordingly, information on good dental hygiene and on case management techniques for helping families who are referred for missed dental appointments was provided during case management/care coordination certification training. "Smile Alabama" dental brochures were made available for care coordinators to utilize in educating families.

As the EPSDT Care Coordination Program was implemented in FY2004, the most frequent reasons for referrals were for 1) assistance with medical compliance, 2) child health needs assessments, 3) community resources, 4) education regarding disease or condition, 5) missed appointments, 6) parenting issues, 7) health insurance assistance, and 8) transportation. Other frequent reasons for referral, presumably of teens and perhaps preteens rather than the age group to which SPM #11 pertains, were pregnancy prevention and counseling regarding STDs, including HIV.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct activities listed under SPM #10.		X		X
2.				



3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Crosscutting (Enabling, Infrastructure-building):

FY 2005 activities concerning this measure are discussed under SPM #10. FHS expects to see additional care coordinators hired and to see the Patient 1st EPSDT Care Coordination Program continue to grow throughout the year. Care coordinators will continue to provide coordination concerning a wide variety of health-related needs, including dental needs.

**c. Plan for the Coming Year**

Crosscutting (Enabling, Infrastructure-building):

Plans for FY 2006 are discussed under SPM #10. FHS expects the EPSDT Care Coordination caseload and the FTEs devoted to this care coordination to continue.

**State Performance Measure 12: *The degree to which the State develops and implements a plan to promote utilization of dental services, particularly utilization of preventive services by low income children***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8	9	11	15	15
Annual Indicator	4.0	9.0	14.0	13.0	13.0
Numerator	4	9	14	13	13
Denominator	15	15	15	15	15
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	15				

**Notes - 2003**

The reason for the lower score in FY 2003, compared to FY 2002, is that we have downgraded

Item #5 on the corresponding checklist from "Mostly Met" to "Partially Met." The rationale for this downward revision follows. Item #5 pertains to partnering with Alabama School of Dentistry in Birmingham (School of Dentistry) staff to survey hospital emergency rooms to collect data on children's emergency visits for oral health conditions. In a study of the Children's Hospital's (in Birmingham) database for FYs 2001 and 2002, the School of Dentistry found that about 1,100 children presented each year in that hospital's emergency room for a dental procedure (per information provided to the Bureau of Family Health Services in FY 2003). However, with the turnover of dental students, management and analysis of the anticipated database was disrupted and is unlikely to resume.

#### **Notes - 2004**

The scored checklist is attached to Section IV.D., SPM #12, "Last Year's Accomplishments."

This measure becomes inoperative in FY 2005, so there are no targets for FY 2006 onward.

#### **a. Last Year's Accomplishments**

##### **Cross-cutting:**

The following provides a context for the reporting year. The Governor's initiative in October 2000 to increase Medicaid reimbursement for dental services to 100% of Blue Cross and Blue Shield of Alabama fees has had far reaching benefits. Statewide, use of dental services by Medicaid-enrolled children increased from a baseline of 25.6% on FY 2000 to 31.2% in FY 2002. Most remarkable was the fact the increase during this time period occurred in 64 of the State's 67 counties. By FY 2003, 34.9% of Medicaid-enrolled children statewide received dental care. Subsequent information pertains to FY 2004 unless stated otherwise.

Additional activities, not mentioned below, designed to promote utilization of dental services by underserved children are discussed under NPM #9.

A checklist of 5 components documenting a plan to promote utilization of dental services by low income children is found in the attachment. In FY 2004 the total score for the checklist continued to be 13. All of the first 4 components were completely met by the reporting period. Briefly, these components pertained to partnership with Medicaid to develop and distribute educational materials on oral health, provision of oral health materials and training on oral health to Health Department staff, collaboration with several external entities regarding oral health, and implementation of a media campaign to promote oral health. The 5th component of the checklist continued to be only partially met. Specifically, the School of Dentistry confirmed that even though the hospital survey mentioned in the 5th component had been done, the final report could not be located, so no data were available to document the outcome of the survey.

Additional activities pertaining to children's utilization of dental services are discussed under NPM #9 and SPM #15.

##### **Direct:**

Statewide in FY 2004, 37.2% of Medicaid-enrolled children received dental care, up from 34.9% in FY 2003 and 25.6% in FY 2000.

Current Medicaid data indicate that of the 168,879 Medicaid children and youth receiving dental services in FY 2004, 149,730 (88.6%) received preventive services. This finding is encouraging, especially when some oral health opinion surveys indicate that low-income populations often assume that dental visits are only necessary for emergency care.

##### **Population-based:**

OHB continued to work with the Medicaid Agency and other partners to implement the State Oral Health Plan, "Smile Alabama!" and other educational initiatives.

##### **Infrastructure-building:**

Oral health training for Patient 1st staff and maternity care coordinators continued. Also continued was distribution of educational literature, videos, oral hygiene supplies and other types of educational strategies designed to promote access to dental care, especially for low-income children.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Alabama Medicaid Agency and other partners to implement the State Oral Health Plan, "Smile Alabama!" and other educational initiatives.			X	X
2. Provide oral health training for Alabama Department of Public Health care coordinators.				X
3. As needs and opportunities arise and particularly targeting children from low-income households, distribute oral hygiene supplies and educational literature, videos, and other materials pertaining to oral health.			X	X
4. Conduct activities under NPM # 9 and SPM #15.	X		X	X
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

This SPM becomes inoperative in FY 2005, so will not be reported on in future MCH applications/reports.

However, collaboration with external entities in order to promote oral health, as well as provision of training on oral health to certain Health Department staff, continues in FY 2005 as the need and opportunities arise.

**c. Plan for the Coming Year**

As stated under "Current Activities," this measure will have become inoperative in FY 2005, so will not be continued in the next needs assessment cycle. Collaboration and provision of training pertaining to oral health will continue, however, as needs and opportunities emerge.

**State Performance Measure 13: *The degree to which programs and policies designed to prevent adolescent pregnancy are implemented and evaluated***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	9	11	13	15	17
Annual Indicator	11	14	14	14	15
Numerator	11	14	14	14	15
Denominator	18	18	18	18	18
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	18				

#### Notes - 2002

The scored checklist is attached to Section IV. D., SPM #13, Last Year's Accomplishments.

#### Notes - 2003

The scored checklist is attached to Section IV. D., SPM #6 (using the CURRENT numbering system), "Last Year's Accomplishments."

During the FY 2004-05 maternal and child health needs assessment, the Bureau of Family Health Services will determine whether this measure will remain operative. If the measure remains operative, criteria will be revised to reflect current programs and issues pertaining to prevention of adolescent pregnancy. Targets for FY 2005 onward would then be revised to reflect the updated criteria.

#### Notes - 2004

The scored checklist is attached to Section IV.D, SPM #13, "Last Year's Accomplishments."

This measure becomes inoperative in FY 2005, so there are no targets for FY 2006 onward.

#### a. Last Year's Accomplishments

Populations Served: Pregnant women, mothers, and infants; children

#### Rationale for Measure:

This indicator flows from the priority need to reduce the occurrence of adolescent pregnancy.

#### Backdrop:

Before FY 2004 the main non-clinical programs administered by FHS to address adolescent pregnancy were the Alabama Unwed Pregnancy Prevention Program (AUPPP), the Alabama Abstinence-Only Education Program (AAEP), the Alabama Community-Based Abstinence-Only Education Program (ACAEP), and the toll-free hotline providing abstinence-based and abstinence-only education. (All are discussed under NPM #8.) Each of these programs was to have had an evaluation or data-collection component, but the degree to which evaluations were reported varied widely. The checklist showing criteria on which this measure is scored is attached.

Of these programs, AAEP (which has been in place since 1998) has demonstrated the strongest evaluation component, in that the university group AAEP contracts with produces periodic, extensive evaluative reports. The ACAEP during its 3-year grant period (FY 2002-2004) produced an evaluation report for each year of the grant period. With respect to previously conducted teen focus groups, a report distributed in January 2000 includes a description of methodology and findings from the evaluation forms distributed to participants. In

May 2004 an evaluative report of AUPPP, prepared by The Alabama State University, was produced, increasing the total score for this performance measure to 15. With respect to the telephone hotline and services to teens in ADPH family planning clinics, no comprehensive evaluation reports have been distributed, which is why ADPH has not achieved the maximum score (18) for this measure. The final criterion for this measure pertains to annual monitoring of adolescent pregnancy rates, which ADPH performs.

Cross-cutting (Direct, Population-based, Infrastructure-building):

As discussed under NPM #8 (see that measure for full discussion), in FY 2004:

1) The toll-free InfoConnection hotline to provide educational information for teens on reproductive health and family planning services continued.

2) AAEP and ACAEP continued functioning. However, ACAEP was discontinued at the end of FY 2004, since its grant period was for FYs 2002-2004.

3) AUPPP was terminated.

AAEP and ACAEP produced an annual evaluative report. No systematically evaluative reports were produced in FY 2004 for the other afore-referenced programs or activities.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. If receipt of federal funds continues, administer the Alabama Abstinence-Only Education Program (AAEP) to prevent teen pregnancy.			X	X
2. Through the above program, channel federal funds to eligible community groups seeking to prevent adolescent pregnancy.			X	X
3. Throughout its operation, continue periodic evaluations of AAEP.				X
4. Provide family planning services to teens coming to CHDs for such services.	X			
5. Through the toll-free InfoConnection hotline, provide educational information for teens on reproductive health and family planning services.				X
6. Annually monitor the statewide adolescent pregnancy rate.				X
7. Conduct activities described under NPM #8.	X	X	X	X
8.				
9.				
10.				

#### b. Current Activities

Crosscutting (Direct, Population-based, Infrastructure-building):

InfoConnection, AAEP, and ACAEP continue. CHDs continue serving adolescents who present there for family planning services. See NPM #8 for other FY 2005 activities for addressing adolescent pregnancy.

This SPM becomes inoperative in FY 2005, so will not be reported on in future MCH applications/reports.

### c. Plan for the Coming Year

Crosscutting (Direct, Population-based, Infrastructure-building):

FY 2005 activities will basically continue in FY 2006. Further, as stated under NPM #8, AAEP plans to submit an application for federal funding to continue providing abstinence-only education to youth aged 17 years and younger. ACAEP plans to submit an application for federal funding to resume providing abstinence-only education primarily to adult role models, as well as adolescents aged 12-18.

As stated under "Current Activities," NPM #11 will have become inoperative in FY 2005, so will not be continued in the next needs assessment cycle. The measure will, however, be replaced by a quantitative indicator for tracking the adolescent pregnancy rate statewide. The new measure will count reported fetal deaths and induced abortions, as well as live births, in the numerator.

**State Performance Measure 14:** *The degree to which the State Children with Special Health Care Needs Program assures public awareness of Title V CSHCN programs and activities among families and public/private service providers*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	3	5	8	10	12
Annual Indicator	3	5	9	10	12
Numerator	3	5	9	10	12
Denominator	15	15	15	15	15
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	0	0	0	0	0

#### Notes - 2002

The scored checklist is attached to Section IV. D., SPM #14, Last Year's Accomplishments. A description of progress on each criterion in the checklist follows.

#### Characteristics:

1. The State CSHCN Program has developed a unique logo and tag line for all public awareness materials that reflects its message and the scope of its activities and has incorporated them in all its brochures and materials.

Score: 2-Mostly Met. CRS developed a unique logo and tag line to use in all its public awareness materials. The first brochure with the new look was printed and also made available in alternative formats. A second brochure has been revised and is in the process of being

printed. Other brochures are being revised with the new look. A CRS public awareness Powerpoint presentation was developed and disseminated to local offices. New, smaller display boards with the new look were ordered for use at local health fairs, etc.

2. The State CSHCN Program has an informational video that can be utilized statewide to disseminate its message and the scope of its activities and services.

Score: 2-Mostly Met. CRS utilized the recommendations of the task force convened in FY 2000 regarding format and content for its informational video. The script is written, and videotaping is underway.

3. The State CSHCN Program has a Web site for families with resource information about and links to services for CSHCN that is updated regularly.

Score: 2-Mostly Met. CRS developed an extensive revision to its current Web site that features its seven service programs. CRS is collaborating with the ADRS Office of Communication and Information and the ADRS Division of Computer Services in its ongoing construction. Competing priorities in the Division of Computer Services have slowed progress on this initiative.

4. The State CSHCN Program has developed and implemented a statewide public awareness plan that disseminates its materials through multiple methods.

Score: 2-Mostly Met. CRS has developed its public awareness plan and has been actively disseminating its newly revised materials through multiple methods, including mail-outs, hand-outs, conference exhibits, presentations, and personal contacts.

5. The State CSHCN Program has developed and implemented staff training on public awareness strategies and uses of materials to ensure a consistent message statewide.

Score: 1-Partially Met. CRS planned a staff-training program to be completed in FY 2004.

Key: 0-Not Met; 1-Partially Met; 2-Mostly Met; 3-Completely Met.

### **Notes - 2003**

The scored checklist is attached to Section IV. D., SPM #14, Last Year's Accomplishments.

A description of progress on each criterion in the checklist follows.

#### **Characteristics:**

1. The State CSHCN Program has developed a unique logo and tag line for all public awareness materials that reflects its message and the scope of its activities and has incorporated them in all its brochures and materials.

Score: 2-Mostly Met. CRS developed a unique logo and tag line to use in all its public awareness materials. Four pieces of material have been revised to include the new look and have also made available in alternative formats. Other brochures are being revised with the new look. The ADRS website and the CRS Non-Medical Vendor directory all incorporate the new look. A CRS public awareness Powerpoint presentation was developed and disseminated to local offices. CRS signage and display boards all include the new look.

2. The State CSHCN Program has an informational video that can be utilized statewide to disseminate its message and the scope of its activities and services.

Score: 2-Mostly Met. CRS utilized the recommendations of the task force convened in FY 2000 regarding format and content for its informational video. The script is written and videotaping is completed. A local newscaster is providing the voice over for the production. A completed video is expected by the end of FY 2004.

3. The State CSHCN Program has a Web site for families with resource information about and links to services for CSHCN that is updated regularly.

Score: 3-Completely Met. CRS, the ADRS Office of Communication and Information, and the ADRS Division of Computer Services developed an extensive revision to its current Web site that features its seven service programs. The website, complete with resource information and program links, is now active and continually updated.

4. The State CSHCN Program has developed and implemented a statewide public awareness plan that disseminates its materials through multiple methods.

Score: 2-Mostly Met. CRS has developed its public awareness plan and has been actively disseminating its newly revised materials through multiple methods, including mail-outs, hand-outs, conference exhibits, presentations, and personal contacts. A Public Awareness Task Force has been convened and will be expanded to include field district and consumer representatives.

5. The State CSHCN Program has developed and implemented staff training on public awareness strategies and uses of materials to ensure a consistent message statewide.

Score: 1-Partially Met. Due to budget constraints, the staff-training program has not been completed. However, meetings have been ongoing and planning has begun to complete this activity.

Key: 0-Not Met; 1-Partially Met; 2-Mostly Met; 3-Completely Met.

#### **Notes - 2004**

(This performance measure will be discontinued for future reporting.)

The scored checklist is attached to Section IV. D., SPM #14, Last Year's Accomplishments.

A description of progress on each criterion in the checklist follows.

#### **Characteristics:**

1. The State CSHCN Program has developed a unique logo and tag line for all public awareness materials that reflects its message and the scope of its activities and has incorporated them in all its brochures and materials.

Score: 3-Completely Met. CRS developed a unique logo and tag line to use in all its public awareness and informational materials. Current materials have been revised and new brochures are developed to include the new look. A CRS public awareness presentation was developed and disseminated to local offices. CRS signage and display boards all include the new look.

2. The State CSHCN Program has an informational video that can be utilized statewide to disseminate its message and the scope of its activities and services.

Score: 2-Mostly Met. CRS utilized the recommendations of a task force convened in FY 2000 regarding format and content for its informational video. The script has been written, videotaping is completed, and a local newscaster has provided the narration for the production. A rough, first cut has been developed with Alabama Department of Public Health, though final edits have not been completed.

3. The State CSHCN Program has a Web site for families with resource information about and links to services for CSHCN that is updated regularly.

Score: 3-Completely Met. CRS, the ADRS Office of Communication and Information, and the ADRS Division of Computer Services developed an extensive revision to its current Web site that features its service programs. The website, complete with resource information and program links, is active and continually updated.

4. The State CSHCN Program has developed and implemented a statewide public awareness plan that disseminates its materials through multiple methods.



Score: 3-Completely Met. CRS has developed its public awareness plan and has been actively disseminating its newly revised materials through multiple methods, including mail-outs, hand-outs, conference exhibits, presentations, and personal contacts. A Public Awareness Task Force has been convened. CRS conducts public awareness exhibits statewide at conferences, health fairs, consumer meetings, etc.

5. The State CSHCN Program has developed and implemented staff training on public awareness strategies and uses of materials to ensure a consistent message statewide.

Score: 1-Partially Met. Due to budget constraints, the staff-training program has not been completed. However, meetings have been ongoing and planning has begun to complete this activity.

Key: 0-Not Met; 1-Partially Met; 2-Mostly Met; 3-Completely Met.

#### a. Last Year's Accomplishments

This measure relates to the priority need to improve health status of CSHCN. The FY 2004 target of 12 was met (scale 0-15, per attached checklist). This indicator has shown consistent progress from its baseline of 5 in FY 2001. The following activities occurred in FY 2004:

##### Population-based:

Signage was installed in 3 CRS offices, including the unique look and tag line as developed for use in all public awareness materials. This look is consistent with other offices statewide and provides a readily recognizable identity for the agency. The CRS look was also placed on staff lab coats and was incorporated into the draft revision of the CRS Policy and Procedure Manual.

The CRS Feeding Clinic brochure was revised to include the CRS look and more accurate, updated wording reflecting services offered. Draft contents for an Audiology Program/Hearing Aid Clinic Brochure were completed. Efforts continue to provide materials in Spanish and other alternative formats (Braille, large print, electronic) and to insure the inclusion of a youth perspective in the revision/development of public awareness materials.

Work continued on A Family Guide to CRS. Planning committee meetings were held and a rough draft was produced.

Work continued on the CRS Video. A local television news anchor recorded the narration and second-stage editing was completed jointly with OCI. A very rough, first cut, working copy of the video was produced by ADPH.

A training was held for CRS Feeding Clinic teams and community occupational and speech therapists who provide services to CRS clients via the non-medical vendor program. This conference relating to the evaluation and treatment of feeding difficulties was held on July 30, 2004. Of the 120 attendees, 82 were vendors for the CRS program. In addition to providing valuable continuing education, it also served to increase public awareness of the CRS program and services offered in an effort to better inform in-state professionals as referral sources.

CRS web pages remain as links from the ADRS website. Collaborations are ongoing among CRS, OCI, and the ADRS Division of Computer Services to maintain useful, updated content.

CRS conducts public awareness/education exhibits throughout the State at conferences, health/career fairs, professional meetings, consumer meetings etc. For FY 2004, the CRS State Office has record of 28 exhibits, potentially impacting 21,204 persons. This number is higher than the 16 reported in FY 2003. Due to the fact that 8 small exhibit settings have been placed in local offices, these numbers should be interpreted with caution as local office staff may have failed to report local exhibitions to the State Office.

CRS maintains a database to track its statewide public awareness efforts. In FY 2004, CRS local office staff reported making 257 public awareness contacts within their communities. This figure demonstrates consistent commitment to public awareness when compared to 258 contacts in FY 2003 and 259 in FY 2002.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporate the new look and tag line into all Children's Rehabilitation Service (CRS) public awareness materials			X	
2. Complete and utilize an informational video on CRS to disseminate its message and the scope of its services			X	
3. Maintain a website with resource information for families			X	
4. Expand the Public Awareness Task Force to include field office staff and consumer representatives			X	X
5. Develop and implement staff training on public awareness			X	X
6. Continue to make informational brochures available in alternative formats (Spanish, Braille, audiotape, electronic file)		X	X	
7. Insure the inclusion of a youth perspective in the revision and development of public awareness materials				X
8.				
9.				
10.				

**b. Current Activities**

**Population-based:**

Due to budget shortfall for FY'05 the number of exhibits conducted by CRS has been greatly limited. Some exhibits are available at no charge, however, most require from \$50 to \$800 to exhibit. To date, 5 exhibits have been completed impacting an estimated 1,310 participants.

Work continues in an effort to complete the CRS video that has been in production for an extended period of time. The lead editor/producer with ADPH left the agency during final work on the project. As a result, CRS is waiting for the Director of the Division of Video Communications with ADPH to appoint another editor/producer to assist in completing the project.

Information has been gathered from CRS field staff to begin drafting an Augmentative Communication Technology Clinic Brochure. The CRS Speech Pathology Program Specialist and the State Supervisor for Professional Services will be working with OCI on this project during the spring of 2005. Draft content for the Audiology Program/Hearing Aid Clinic Brochure will be submitted to OCI. CRS plans to place all new brochures and the completed CRS video on the ADRS website.

Plans are to pursue completion of A Family Guide to CRS. Several major program changes have occurred since the first draft was produced and these now will need to be included. Work will continue on this in the summer of 2005.

The revised CRS Policy and Procedures Manual, including the CRS look, is now available in print and via the ADRS intranet for easy access. This is the first complete revision of the

manual in 10 years. The CRS Diagnostic Code Book and the CRS Infection Control Manual were updated, including incorporation of the CRS look. Both were placed on the ADRS intranet in January 2005.

Work has begun on translating the new CRS Feeding Clinic Brochure into Spanish and on making it available in alternate formats. This is to be completed by the summer of FY 2005.

CRS maintains and updates web pages at the ADRS web site that feature information about the agency's services, enrollment procedures, the Parent Connection Program, the Youth Connection Program, and links to other State and national resources.

**Infrastructure-building:**

The CRS Public Awareness Task Force continues, though it has met has irregularly. Tentative plans include the expansion of the task force to include representatives from field offices and consumers and the provision of statewide training to staff on public awareness strategies to insure a consistent statewide message.

**c. Plan for the Coming Year**

Continual progress has been made in the area of public awareness area over the past 5 years. Although efforts to promote public awareness of the State CSHCN Program will continue at State and local programmatic levels, the formal reporting of this measure will be discontinued. New state performance measures related to CYSHCN have been established based upon priority needs as identified during the current needs assessment process.

**State Performance Measure 15: *The percent of Alabama dentists who actively provide dental services for Medicaid-enrolled children***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	21	26	31	36	41
Annual Indicator	26.6	27.1	30.4	34.0	36.4
Numerator	499	518	579	649	697
Denominator	1878	1912	1907	1907	1914
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	46	46	46	46	

**Notes - 2002**

The numerator is the number of dental providers enrolled in the Alabama Medicaid Program in FY 2002, whether or not they submitted a claim during the reporting year. The denominator is

the number of active, licensed Alabama dentists in FY 2002, per Alabama Board of Dental Examiners records.

The added targets for FYs 2006 and 2007 are the same as the target for FY 2005. Targets for 2005-2007 may be revised in FY 2004, based on trends over a 5-year period and an appropriate baseline.

#### Notes - 2003

The numerator is the number of dental providers enrolled in the Alabama Medicaid Program in the corresponding FY, whether or not they submitted a claim during the reporting year. The denominator is the number of active, licensed Alabama dentists in the corresponding FY, per Alabama Board of Dental Examiners records.

The target for FY 2005 is retained for FYs 2006-2008. Whether this measure will continue to be operative will be determined during the FY 2004-05 maternal and child health needs assessment.

#### Notes - 2004

Please see year 2002 or 2003 notes above for additional comments pertaining to this item.

##### a. Last Year's Accomplishments

In FY 2004 the numerator for this measure increased to 697 providers (versus 649 providers in FY 2003), and the denominator remained unchanged at 1,907. Accordingly, the percentage of Alabama dentists who actively provide dental services for Medicaid-enrolled children increased to 36.5% (up from 34.0% in FY 2003).

##### Infrastructure-building:

Activities in FY 2004 revolved around recruitment and retention of dental providers to serve Medicaid-enrolled children. OHB worked with Medicaid in a variety of ways to identify potential new providers, as well as to identify, from dental claims data, dentists who no longer treated Medicaid-enrolled children. Efforts particularly focused on rural Alabama counties where the number of dental providers who served Medicaid-enrolled children was low.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Alabama Medicaid Agency to recruit and retain dental providers to serve Medicaid-enrolled children, with a particular emphasis on rural counties.				X
2. See SPM #13.			X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

##### b. Current Activities

This SPM becomes inoperative in FY 2005, so will not be reported on in future MCH applications/reports. The previously described infrastructure-building activities continue in FY 2005, however.

#### c. Plan for the Coming Year

As stated under "Current Activities," this measure will have become inoperative in FY 2005, so will not be continued in the next needs assessment cycle. The measure will, however, be replaced by another pertaining to oral health. Medicaid and OHB will continue seeking ways to increase the number of Alabama dentists who provide services to Medicaid-enrolled children.

## E. OTHER PROGRAM ACTIVITIES

### ADPH OTHER PROGRAM ACTIVITIES

#### Care Coordination:

Care coordination, which mainly involves enabling and infrastructure-building services, helps patients to access and obtain maximum benefit from needed health-related services. Provision of care coordination by ADPH is extensively discussed in Section III.E and under SPMs #10-11. This service, as provided by ADPH, is also mentioned under NPMs #8, #12, #14, and #18. The frequent allusion to care coordination illustrates ADPH's commitment to providing this valuable service. As of June 2004, the 2 channels through which ADPH provides care coordination are Plan First, the Medicaid Family Planning Waiver discussed in Section III.A, and Patient 1st, Medicaid's PCCM. The EPSDT Care Coordination Program, discussed in many places in this document, is implemented under Patient 1st, the primary channel through which ADPH provides care coordination.

As of early FY 2005, adults enrolled in Patient 1st are eligible for care coordination, which allows ADPH care coordinators to serve Patient 1st enrollees of all ages. For example, care coordinators are now reimbursed by Medicaid for providing information and counseling on birth control methods and STDS, including HIV, to adults. Reimbursement for provision of care coordination services to adults is especially important for Medicaid-enrolled women receiving family planning services. That is, under Plan First, the Medicaid Family Planning Waiver, Medicaid does not reimburse for care coordination of Medicaid-enrolled persons. Now that Medicaid reimburses for care coordination for Patient 1st enrollees, however, eligible providers can be reimbursed for providing family-planning-related care coordination to Medicaid enrollees. In addition to providing the previously mentioned information, care coordinators can assist in connecting women to primary care providers and needed community resources.

Care coordination is enabling in nature but requires a great deal of infrastructure building. One infrastructure-building task, not discussed elsewhere in this document, is the development of a centralized referral system for care coordination referrals. Discussion of this endeavor follows. Currently, referrals from Child Health workers in CHDs are sent via e-mail to FHS's Social Work Consultant, who sends the referrals to PHA Social Work Directors statewide for distribution to CHD care coordinators. ADPH central-office staff can track these referrals through the Case Management/Care Coordination electronic documentation system (ACORN). To extend and improve this system, FHS is seeking to develop the Centralized Referral System for Care Coordination. As a corollary, FHS is seeking to hire a masters-prepared social worker to coordinate the Centralized Referral System for Care Coordination. The Bureau anticipates designing a website that will be accessible, via the internet or faxing, to Medicaid-participating physicians and dentists.

#### Direct:

#### Alabama Childhood Lead Poisoning Prevention Program (ACLPPP):

The goal of this program, funded by the Centers for Disease Control and Prevention, is to eliminate childhood lead poisoning by 2011. Case Management is provided for all children with a confirmed

blood lead level equal to or greater than 10 ug/dL. Environmental inspections are incorporated into the management of blood lead levels equal to or greater than 15 ug/dL. In FY 2004, 16,509 blood lead screenings were reported among children aged 6 through 72 months. Of these screenings, 192 (1.1%) resulted in confirmation of an elevated blood lead level. Universal screening of children aged 6 through 72 months is conducted in 7 high-risk counties, while the remaining counties follow a targeted screening protocol, under which only children meeting certain social/medical criteria are screened. Efforts to increase awareness of lead-safe practices among parents, property owners, renovators and child health providers were addressed statewide through primary prevention activities. The ACLPPP developed an Elimination Workgroup to build partnerships and identify goals for relevant parties to ensure the elimination of childhood lead poisoning by 2011.

Population-based:

Toll-free MCH Hotlines (Form 9):

There were 1,628 calls to the Healthy Beginnings Hotline during FY 2004, up from 992 calls in FY 2003. Most callers were seeking information about WIC; however, the hotline continued to receive calls regarding prenatal care, child health, immunizations, and Medicaid eligibility. Calls about prenatal care and child health issues have decreased over the past several years as the private sector has assumed responsibility for the SOBRA Maternity and the Patient 1st Programs.

#### CRS OTHER PROGRAM ACTIVITIES

Population-based:

CRS maintains toll-free lines, in operation during normal business hours, in the CRS State Office and 15 district offices. There were 41,469 calls to CRS's toll-free lines in FY 2004. This number is about 8% lower than the 44,863 calls received in FY 2003, but up from 40,556 in FY 2002 and from the FY 1997 baseline of 32,640 calls. Usage of cell phones and area calling plans may contribute to the decreases noted in the number of calls to the toll-free lines.

## F. TECHNICAL ASSISTANCE

### FHS's TECHNICAL ASSISTANCE NEEDS

#### SSDI Project

The SSDI Project is FHS's primary means of support for data-related technical assistance. In FY 2003 the Epi/Data Branch assumed responsibility for coordinating the State's SSDI Project. The primary goal of the current (September 30, 2003 through August 31, 2006) SSDI Project is to enable FHS to further develop its capacity to manage, analyze, and report information from MCH databases listed in HSC #9A, with continued focus on "annual linkage of birth records and WIC eligibility files" and "annual linkage of birth records and newborn screening files." Secondary foci of the primary goal are 1) renewed exploration of the feasibility of linking birth records and Medicaid files, developing a statewide hospital discharge database, and/or developing a statewide birth defects registry; and 2) enhancement of the Bureau's capacity to analyze PRAMS data. The proposed project has 3 secondary goals: to maintain and further develop the Bureau's capacity to 1) report valid estimates for the performance/outcome measures and health systems capacity indicators (in addition to HSC #9A) in the MCH Services Block Grant; 2) conduct ongoing MCH needs assessment, including the comprehensive FY 2004-05 MCH needs assessment, to be submitted concurrently with this MCH 2004 Report/2006 Application; and 3) prepare and disseminate various reports of needs assessment findings, with the reports being tailored to particular readerships.

The most current report of Alabama's SSDI Project, submitted to HRSA on June 15, 2005, is in Appendix E, available as described in Section III.A. A brief description of SSDI activities follows. Largely using resources funded by the SSDI grant, the SSDI Coordinator has electronically linked CY 2000 Alabama live birth records to information from CY 2000 newborn screening billing records. Further, she has electronically linked about 85% of FY 2001 WIC prenatal registration records to CY 2000-2001 live birth records. Additionally, the SSDI Coordinator has produced 2 policy/protocol manuals that are available upon request: 1 on linking live birth records to newborn screening billing files, and 1 on linking live birth records to WIC prenatal registration records. In FY 2006 FHS will

explore the feasibility of linking live birth records with Medicaid records. FHS considers it highly unlikely that a statewide hospital discharge database or a statewide birth defects registry will be developed in the near future. This view is based on previous experience and consultations, as well as the lack of a statewide, coordinated infrastructure for a centralized, statewide birth defects registry or hospital discharge database. The SSDI Project is further discussed under Section III.E.

#### FHS's Suggestions for Regional Technical Assistance

FHS suggests regional workshops on 2 topics. We believe that these workshops would be helpful to other Title V Programs, as well as to FHS.

First, we suggest that MCHB consider providing regionally based, annual updates regarding the MCH report/application guidance and web-based reporting package. We further suggest that these updates be provided in several locations around the country, without charge to the states. Compared to the updates currently provided at the Association of Maternal and Child Health Programs' (AMCHPs') annual conference, regional trainings would allow more interaction among regional stakeholders and MCHB. Further, providing the updates without cost would remove potential financial barriers to the attendance of persons who prepare the MCH reports/applications but are not members of AMCHP.

Further, we suggest that MCHB consider providing regionally based, hands-on workshops regarding analysis of the 2003 National Survey of Children's Health database. Such workshops could promote efficient, informed utilization by State Title V Programs of that database, which should be a useful tool when evaluating or planning policy and programs concerning children and youth.

#### CRS's TECHNICAL ASSISTANCE REQUEST

Further technical assistance is requested by CRS in 1 area during FY 2005. The agency would like to use technical assistance monies for further consultation in data gathering and implementation of activities related to the Alabama Healthy People 2010 initiative.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

#### V. BUDGET NARRATIVE A. EXPENDITURES

##### ADPH

/2004/ Form 3: State MCH Funding Profile

Line 1 (Federal Allocation) -- In FY 2004 ADPH expended \$194,182 in excess of the federal award for FY 2004. This excess was used to pay FY 2003 expenditures in FY 2004.

Line 3 (State Funds) -- In FY 2004 Total State Funds expended decreased from budget by 48.5%. This decrease was due to a FY 2004 budget that was based on FY 2002 activity which was prior to revenue shortfalls that affected spending in late 2003 into 2004 (See Section III. B.). FY 2004 was comparable to those in FY 2003. Expenditures and activity will continue to decline as the Department's role in providing services and the competition for decreasing federal/state funding increases.

Line 6 (Program Income) -- In FY 2004 Program Income exceeded the budget by over 120%. This increase was the result of an FY 2004 budget that was based on a lower FY 2002 activity. Also, a previous template error in FY 2003 resulted in an adjustment to Program Income to reflect under projection of Medicaid dollars. In addition, approximately \$4.0 million program income from Family Planning Care Coordination was previously excluded from the calculations (corrections have been made to ADPH spreadsheet to reflect this change in future submissions). EPSDT Care Coordination, which replaced Medically at Risk in 2004, had combined increase of approximately \$1.7 million over FY 2003.

/2004/ Form 4: Budget Details By Types of Individuals Served and Sources of Other Federal Funds

Line I.a. (Pregnant Women) -- Expenditures in this category were 19.8% less than budget and represent approximately 83% of the funds expended in FY 2003. This is a continuing downward trend in services performed in our CHDs, as discussed in previous submissions (See Section III.A.B.).

Line 1.f. (Administration) -- In FY 2004 expenditures decreased 18.6% compared to the budget. In FY 2003 approximately \$985,000 in Departmental resources were made available to the Program. These funds were not available in FY 2004.

/2004/ Form 5: State Title V Program Budget and Expenditures by Type of Services

Line III (Population Based Services) -- Expenditures for this category exceeded budget by 46%. In FY 2004, EPSDT Care Coordination replaced the Medically at Risk Program. Combined expenditures for these programs increased approximately \$2.1 million.

Line IV. (Infrastructure Building Services) -- In FY 2004 expenditures decreased 50.6% from budget. FY 2004 budget was based on FY 2002 expenditures that included programs at peak growth that were not included in the budget for FY 2002. This inflated the FY 2004 budget in a year that experienced funding cuts.

##### CRS

/2004/Form 3: State MCH Funding Profile

Line 6 (Program Income) -- The only significant variation in expenditures for CRS was in Program Income. Expenditures for FY 2004 were \$2.1 million less than the budgeted amount. The budgeted funds reported each year in Program Income are only an estimate. Therefore, actual expenditures more accurately reflect the funds received.

## **B. BUDGET**



## V. BUDGET NARRATIVE

### B. BUDGET

#### ADPH

***//2006/. In FY 2006, the Department anticipates overall spending to be down in ADPH's budgeted MCH cost centers when compared to FY 2005. This does not take into consideration any unforeseen Federal reductions in Title V funding to the State. Additionally, ADPH expects to see a decrease in the Family Planning services from approximately \$28.2 million dollars in FY 2005 to approximately \$26.8 million dollars in FY 2006. This reduction is due to the loss of \$1.4 million in DHR funding for contraceptives. For FY 2006, Title X increased the grant award by \$173,588 to \$4.941 million dollars. Also, for FY 2006 there is potential for growth in the Patient First Adult Care Coordination which started in March 2005. As the federal and state appropriations are contracted, additional budget reductions are anticipated in FY 2006. //2006//***

#### CRS

See Forms 2-5. Funds spent on CYSHCN will support activities to address NPMs #2-#6 and [[[CRSSPMs #1 and 2]]]. Under Other Federal Funds, anticipated funding is included for the MCHB Comprehensive Core Hemophilia Grant and for the Alabama EIS for the provision of early intervention services to Part-C eligible infants and toddlers.

Anticipated use of the budgeted monies is justified by the level of the pyramid:

#### Direct Health Services

CRS-Includes direct community-based services of specialty medical care, care coordination, and ancillary care through the CRS specialty clinic programs and information and referral services for CYSHCN who are uninsured or under-insured for needed services and supports, including SSI-eligible children 0-16 years.

#### Enabling Services

CRS-Includes transportation reimbursements, translation services, coordination with local educational agencies and with vocational rehabilitation services for youth transition services, a toll-free line in every district office, and parent consultant activities to assist families to advocate for their needs and to provide family support services offered through district offices.

#### Population-Based Services

CRS-Includes State activities to screen/identify CYSHCN as early as possible and outreach to families to provide information and assistance in seeking and attaining services through multiple awareness mechanisms.

#### Infrastructure-Building Services

CRS-This includes State level administrative activities to support the CRS community-based service system and the continuous quality assurance process, including standards of care and outcome measures. Also includes interagency collaboration to improve/expand the service delivery system for CYSHCN (including those with TBI), in-service training, health status surveillance and other measurement activities. At the community level, includes staff, family, and youth support for local system development activities.

Other expenditures for infrastructure include a redesigned CRS management information system to collect and analyze data, the use of communication/information technology for public awareness and client/family education as appropriate, and the efforts towards the Alabama Healthy People 2010 Action Plan for CYSHCN.

See Forms 2-5. ADPH contracts with ADRS, Division of CRS, for services to CSHCN and allocates Title V dollars to the agency for this effort. Due to budget constraints in the State in FY 2004, ADPH reduced Title V funding to CRS to the required 30% of the federal MCH block grant (about 3.7 million

dollars) compared to previous funding levels at 35.46% (about 4.5 million dollars). For FY 2005, however, ADPH increased its allocation to the State CSHCN Program to 32% (about 3.9 million dollars), thus Budgeted Federal Allocation (Line 1, Form 3) represents this change. This level of funding is expected to continue for FY 2006. CRS continues to overmatch its federal dollars through its State allocation by over 3 million dollars. For FY 2004, budgeted monies for State Funds (Line 3, Form 3) represent an additional \$332,528 allocated by the State legislature. For FY 2005, in addition to its State allocation (7.7 million dollars), the CRS Budget Request includes funds from the Alabama EIS for the provision of early intervention services to Part-C eligible infants and toddlers (2.1 million dollars), a separate State allocation for the Alabama Hemophilia Program (1.1 million dollars), and program income from 3rd party reimbursements (11.7 million dollars). These funds, in conjunction with the Federal Title V allocation, comprise 99.9% of the projected CRS budget for FY 2005. Budgeted monies under Other Federal Funds (Line 10, Form 2) are significantly different from FY 2004 as \$16,500 was represented in additional funds from a grant through the Champions for Progress Center to host a conference related to Healthy People 2010. CRS continues to receive \$28,700 from MCHB as a sub grantee to Georgia to provide comprehensive care to persons with hemophilia. CRS anticipates no other federal funds for special projects or grants in FY 2006. CRS has requested an additional \$2.6 million from the State legislature for FY 2006, as represented in State Funds (Line 3, Form 3). An additional \$1 million is requested for the Alabama Hemophilia Program, as represented in Other Funds (Line 5, Form 2). Also for FY 2006, anticipated Program Income (Line 6, Form 3) has been modified to more accurately reflect the third party reimbursement trends from FY 2004 and FY 2005.

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.